

# Advocacy: The Experience of Psychiatric Nurse Case Managers

By

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A Thesis

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*Keep your face always toward the sunshine – and shadows will fall behind you.*

– Walt Whitman

### **Abstract**

The concept of advocacy has been deemed integral to nursing practice and is a component of a recovery-oriented mental health care system, yet few nursing advocacy studies have taken place within mental health care settings. Advocacy has been regarded by previous scholars as central to case management practice. A study focused within the role of case management practice provided one context in which, to begin an exploration of advocacy for nursing within mental health settings. The purpose of this research was to explore the advocacy experiences of psychiatric nurse case managers in an ambulatory care setting, who work with adults living with a severe mental illness. Six psychiatric nurse case managers were interviewed using van Manen's hermeneutic phenomenological method. Data analysis began during the data collection phase, where initial interviews were transcribed, coded, and themes were identified. A metaphorical journey was used to organize the themes generated from the information collected, which included: embarking on a journey, resources for the journey, travelling solo and with others, the journeys and time, types of journeys, and collective journeys. The nurse participants defined advocacy as a dynamic process that involved speaking on behalf of others, supporting autonomy, and upholding social justice. The nurses travelled on the roads towards recovery, as defined by the person or family, by mainly focusing their advocacy activities on a micro individual or family level. Implications for practice, education, and policy are discussed, along with suggestions for future research.

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## **Chapter 1 - Introduction**

Advocacy is a phenomenon that is familiar to the nursing profession. Nurses see firsthand the end results of poor access to health care or poor health maintenance (Grace, 2014) and are known to protect and advocate for the well-being, safety, values, and rights of patients (Bu & Jezewski, 2007). Advocacy is widely recognized by experts in health care delivery as important for patients, the nursing profession, the health care system, and society (Bu & Jezewski, 2007; Bu & Wu, 2008; Jansson et al., 2015; Jugessor & Iles, 2009). Advocacy is regarded as a professional expectation in ethical codes of conduct by various nursing associations and regulatory bodies (Canadian Nurses Association [CNA], 2008; International Council of Nurses [ICN], 2012; Registered Psychiatric Nurses of Canada [CRPNC], 2010).

Stronger nurse advocates struggle less with moral distress and subsequent job dissatisfaction. Furthermore, supporting the development of strong advocacy skills has the potential for a positive impact on nurses' satisfaction with their careers (McSteen & Peden-McAlpine, 2006) and is a key factor in patient safety (Rainer, 2015). Advocacy can have therapeutic effects and enable solutions to the problems of everyday life (Stylianios & Kehyayan, 2012).

The concept and practice of advocacy in the nursing context is complex and not easily understood (Bu & Jezewski, 2007; Jugessor & Iles, 2009; Macdonald, 2006; Selanders & Crane, 2012; Vaartio & Leino-Kilpi, 2005). Despite the importance that nurses attach to advocacy, empirical studies related to the practice of advocacy in nursing are limited in number (Bu & Jezewski, 2007; Hanks, 2010; Jugessor & Iles, 2009; Macdonald, 2006; Vaartio & Leino-Kilpi, 2005), which is problematic given that members of the nursing profession now identify advocacy

as a major component of political, social, professional, and academic practice (Selanders & Crane, 2012).

Most of the available nursing advocacy literature appears to be focused on opinion and few empirical studies exist. A limited number of instruments exist that measure nursing advocacy (Bu & Wu, 2008; Hanks, 2010b; Jansson et al., 2015; Vaartio, Leino-Kilpi, Suominen, & Puukka, 2009a) and few are rigorously designed (Bu & Wu, 2008). Several authors suggested that advocacy was context based (Hanks, 2008, 2010; Josse-Eklund, Jossebo, & Sandin-Bojö, 2014; Negarandeh, Oskouie, Fazollah, & Nikraves, 2008; Wilde-Larsson, & Petzäll, 2014; Vaartio & Leino-Kilpi, 2005) and the need for more descriptive studies related to the experiences of nurse advocacy from more nursing specialties has been identified (Hanks, 2008; O'Connor & Kelly, 2005). Many of the studies are based on qualitative design methodologies with vulnerable populations (Copp, 1986) and in emergency (Watt, 1997), general hospital (Negarandeh et al., 2008; O'Connor & Kelly, 2005), community case management (Hellwig, Yam, & DiGiulio, 2003; Tahan, 2005; Yamashita, Forchuk, & Mound, 2005), perioperative (Boyle, 2005), critical care (Breeding & Turner, 2002), military (Foley, Minick, & Kee, 2000), and medical-surgical settings (Hanks, 2008, 2010b; Manaouil, Manaouil, & Jardé, 2012; Sellin, 1995; Snowball, 1996). However, strikingly few studies have taken place in psychiatric or mental health settings (Juggessor & Iles, 2009; Vaartio & Leino-Kilpi, 2005).

Advocacy has been deemed integral to case management practice (Hellwig, Yam, DiGiulio, 2003; Tahan, 2005; Yamashita et al., 2005). A study, focused within the role of case management practice, provided one context in which to begin an exploration of advocacy, for nursing within mental health settings. Stylianos and Kehyayan (2012) suggested that institutional care in mental health has moved from hospital to the community and for vulnerable



individuals, issues arising in the community may be of equal concern to those in a hospital setting.

For the purpose of this study, case management providers were defined as having the ability to “demonstrate expertise in complex health and social needs planning. As leaders in coordination and facilitation, Case Management Providers integrate all Case Management roles to promote and optimize the health and well-being of targeted client populations” (National Case Management Network of Canada, 2012, p. 7). Nurses may work as case managers and have specific psychiatric and mental health knowledge, which includes knowledge of consumer/survivor issues, crisis intervention, mental disorders, associated medications, counseling and therapy models, as well as knowledge of psychiatric nursing and rehabilitation (Forchuk, Ouwerkerk, Yamashita, & Martin, 2002).

Anthony, Cohen, Farkas, and Cohen (1988) suggested that one of the functions of case management was to help individuals living with long-term psychiatric disabilities or severe mental illness get the services they wanted and needed. Individuals living with psychiatric disability may have been diagnosed with mental illnesses, which limited their abilities to perform certain tasks, functions, and roles, and may not be interacting well in their living, learning, social, and/or working environments (Anthony, Cohen, Farkas, & Gagne, 2002).

Case managers may work in different settings (Forchuk et al., 2002; Tahan, 2005; Yamashita et al., 2005). Ambulatory-care has been defined as outpatient treatment given at a hospital to non-resident patients. The push for early patient discharges from hospitals required that more treatment be provided in ambulatory care settings, which led to an increase in demand for case managers (Ezeonwu, 2015). The choice of an outpatient care setting allowed for greater homogeneity of the participant population and added further context for this study.

The purpose of this research was to explore the advocacy experiences of psychiatric nurse case managers, who worked in an ambulatory care setting with adults living with a severe mental illness. Hermeneutic phenomenology is an appropriate methodology when little previous research is available and need for further clarity on a chosen topic is apparent (Streubert & Carpenter, 2011). Phenomenological research is the study of lived experience (van Manen, 1997) and was utilized to answer the question: What are the advocacy experiences of psychiatric nurse case managers, who work in an ambulatory care setting, with adults living with a severe mental illness? The aim of phenomenology is to gain a deeper understanding of the nature and meaning of everyday experiences through retrospective reflection (van Manen, 1997). The development of theory may be derived from reflection (van Manen, 1997). Theory then is used to enlighten practice (van Manen, 1997). Research findings may assist psychiatric nurse case managers in developing skills and more meaningful practices related to advocacy, which is in keeping with a recovery, or client-oriented system of mental health care. Additional theory, practice, policies, and education related to advocacy in nursing also, may be derived from the findings of this study.

Chapter Two, the literature review, is focused on advocacy in the nursing context and was undertaken prior to conducting the research study. Chapter Three contains the methodology section of the study and the data analysis or findings of the study are reviewed in Chapter Four. A discussion of the findings and implications for nursing practice, education, and policy comprises Chapter Five. The strengths and limitations of the study and directions for further research also are reviewed along with the conclusion, in Chapter Six.

## **Chapter 2 - Literature Review**

A paucity of research on advocacy is problematic for psychiatric nursing, although greater attention has been paid to the concept in recent years (Arboleda- Flórez & Stuart, 2012; Halter, 2008; Jugessor & Iles, 2009; Ross & Goldner, 2009; Toda et al., 2014). Advocacy is important for psychiatric nurses because advocacy is a key component of a recovery-oriented mental health system (Mental Health Commission of Canada [MHCC], 2015; Stylianos & Kehyayan, 2012; World Health Organization [WHO], 2003). Jugessour and Iles, (2009) suggested that the majority of papers related to advocacy in nursing were generic and may not be appropriate to mental health. Additionally, recommendations for practical guidance about organizational changes, which could support nurse advocacy, were needed (Jugessour & Iles, 2009).

An extensive search of the nursing advocacy literature was conducted using PubMed and CINAHL databases. Classic works in nursing advocacy literature were reviewed. Advocacy was mentioned frequently in documents from prominent national and international health and mental health organizations. The review begins with the historical foundations of advocacy in nursing including philosophical models and various perspectives on nursing advocacy. A review of related terms such as autonomy, empowerment, and paternalism were used to provide some conceptual clarity. The factors, barriers, and challenges associated with nurse advocacy have been discussed as important related themes. Advocacy, recovery, and mental health within the context of stigma and social justice associated with mental illness were used to highlight the importance of this phenomenon to psychiatric nursing. The literature review has been concluded with implications for research and practice.

### **Foundations of Advocacy in Nursing**

Florence Nightingale has been thought to have laid the foundation for advocacy in nursing and to have established the expectation that nurses should advocate for their patients (Becker, 1986; Selanders & Crane, 2012). Nightingale did not address advocacy directly in her writings although she demonstrated advocacy throughout her lifetime through the promotion of human rights and visionary leadership activities (Selanders & Crane, 2012). During the Crimean War, Nightingale challenged the military system and the unsanitary conditions produced in hospitals (Gaylord & Grace, 1995). Gaylord and Grace (1995) argued that for Nightingale, patient advocacy was ‘putting the patient in the best condition’ so that nature could do its work, which meant understanding the best condition for that individual. The best condition was defined by the patient and was used to dictate nursing actions (Gaylord & Grace, 1995).

The *Code of Ethics for Nurses* (ICN, 2012) was written as a guide for nursing action and has served as the standard worldwide since 1953. The term advocacy was not mentioned in nursing literature until the ICN introduced the concept in professional codes in 1973 (Becker, 1986; Vaartio & Leino-Kilpi, 2005). Prior to the 1970s, early nursing educators emphasized conformity and subservience particularly towards physicians (Selanders & Crane, 2012). In 1973, references referring to obedience to physicians’ orders were removed from the ICN *Code of Ethics* (Foley, Minik, & Kee, 2000). In 1976, the American Nurses’ Association removed loyalty to the physician, as an ethical behavior for nurses, from their code of ethics and loyalty and advocacy for the patient was emphasized (Becker, 1986). Mallik and Rafferty (2000) suggested that the fight for civil rights in the United States of America (USA) in the 1960s may have contributed to the changes in the traditional functioning of health care and may have laid the foundation for the patients’ rights movement. The professionalized patient advocate role was

thought to originate in the USA and was later adopted in the United Kingdom (UK) (Mallik, 1998).

During the 1980s, ethical decision-making and autonomy for nurses was a significant theme and the connection to advocacy was made explicit in the literature (Mallik & Rafferty, 2000). Patients' rights, living wills, and refusal of treatment also were reflected in nursing studies during this decade (Mallik & Rafferty, 2000). Advocacy as a concept became more prominent in nursing research during the 1990s (Jugessor & Iles, 2009; Mallik & Rafferty, 2000; Selanders & Crane, 2012; Vaartio & Leino-Kilpi, 2005) and empowering patients as consumers and autonomous decision makers was emphasized (Mallik & Rafferty, 2000). Advocacy now has been highlighted in the codes of conduct of most Western countries' nursing regulatory bodies (Jugessor & Iles, 2009), however very little discussion has been noted, encouraging ways that nurses can best apply advocacy in practice (Hewitt, 2002; Macdonald, 2006).

**Philosophical models of nursing advocacy.** The works of Curtin (1979), Gadow (1980), and Kohnke (1982) frequently have been cited in the nursing advocacy literature. Curtin (1979) and Gadow (1980) viewed advocacy as a philosophical foundation of nursing, which occurred in the dyadic context of the nurse-patient relationship.

Curtin (1979) argued that human beings were entitled to certain human rights because they were born as humans and the end purpose of nursing was to assist with the welfare of other individuals, which was deemed as human advocacy. The nurse-patient relationship was considered to be based on common humanity, human needs, and human rights (Curtin, 1979). Human beings could not be fragmented and the essential elements for the full development of persons were viewed as freedom, respect, and integrity, which were crystallized as human rights (Curtin, 1979). Nurses' proximity to patients has been viewed as placing the profession in a

unique position to attend to the patient as a holistic being. Curtin (1979) proposed that disease damages humanity through the loss of independence, loss of freedom of action, interference with ability to make choices, and the power of health care professionals. The essence of human advocacy has involved explanation and working together within the nurse-patient relationship for the purpose of assisting patients to define their goals (Curtin 1979). The nurse supported the individual's decision making and assisted the patient to find meaning in living or dying (Curtin, 1979).

Gadow (1980) thought that the essence of nursing was existential advocacy, which was the nurse's participation with the patient in determining the unique meaning that the experience of health, illness, suffering, or dying had for that individual. Similar to Curtin, Gadow (1980) proposed that the nurse could not determine the best interest of the patient; only the patient could determine what was in his or her best interest. The nurse, in the role of advocate helped persons to become clear about their goals and assisted them to clarify their values (Gadow, 1980). The nurse was viewed as having the ability to foster a patient's self-determination (Gadow, 1989). Gadow (1980) acknowledged that some of the features of the nurse-patient relationship created potential for paternalism. The most crucial test for the nurse enacting the advocacy role occurred when the patient was silent and not able to express values and choices (Gadow, 1989).

Approaches such as utilitarianism and beneficence were thought to be tempting alternative moral choices for nurse actions (Gadow, 1989). In the utilitarianism position, the patient was indifferent to any outcome and had no preference for one outcome over another (Gadow, 1989). In the beneficence position, commitment was to the individual patient's best interest yet the professional was assumed to know with greater accuracy and certainty than do patients themselves as to their best interest (Gadow, 1989). Gadow (1989) viewed advocacy as the

opposite of utilitarianism and beneficence. Gadow (1989) described three ways in which the nurse, who was committed to the self-determination of the patient, accessed the patient's silent world. Gadow (1989) suggested that accessing a patient's advance directive, considering the voiced proxy instructions from friends or family, or using the nurse's subjective awareness of the patient's goals, as three avenues for attempting advocacy with silent patients. Gadow (1989) explained that through the experience of embodiment - of nurse and patient, the avenue to subjectivity, and the essential basis for moral commitment to advocacy could be enacted. The nurse and silent patient related as the nurse attended to the relationship through proximity and intimacy of physical caring. The nurse embodied the feelings, sensitivity, and authenticity of the patient and learned to speak for him or her because of being with him or her and understanding his/her goals (Gadow, 1989).

Kohnke (1982) held a more pragmatic view of advocacy (Mallik, 1997a; Negarandeh et al., 2008) and argued that advocacy existed on three levels: advocacy for oneself, advocacy for clients, and advocacy for one's larger community. One must first advocate for the self before advocating for others (Kohnke, 1982). In order to be an advocate, one needed to be informed and have acquired the necessary knowledge as well as knowing oneself before making informed decisions. Furthermore, choices and consequences must have been considered and by making a decision, one accepted responsibility for the consequences (Kohnke, 1982).

Jugessur and Iles (2009) conducted a literature review on mental health nursing and advocacy from a UK perspective. The authors critiqued and analyzed the nursing advocacy models by Curtin, Gadow, and Kohnke, as applied to mental health nursing, and found that these models were a better fit with the nursing of physically ill persons rather than with the nursing of persons living with mental illness. They suggested that these models were not entirely

appropriate for use with mental illness given that an individual living with mental illness may lack capacity to make rational decisions (Jugessur & Iles, 2009). A conflict of interest was thought to arise between the client's rights to autonomy and the nurse's legal and professional duty of care (Jugessur & Iles, 2009). Psychiatric advance care directives allowed individuals to state their preferences for future treatment at times when they were unable to make decisions (Khazaal et al., 2014). Jugessur and Iles (2009) recognized that advance care directives were one means of mitigating the nurse's subjectivity in making decisions for the person. Joint crisis plans (Khazaal et al., 2014) or wellness recovery action planning (WRAP) tools also helped the individual to find ways to self-manage and deal with triggers associated with distress or crisis (Slade et al., 2014).

**Other perspectives on nursing advocacy.** Mallik (1997b) and Chafey, Rhea, Shannon, and Spencer (1998) held the viewpoint whereby the nature of advocacy was triadic and not concerned just with the relationship between the nurse and the patient, but also with others in the environment. Jezewski (1993) proposed a model of 'cultural brokering' derived from the discipline of anthropology to explain nurse advocacy. In the cultural brokering model, the health care system was viewed as a different culture and the nurse who was advocating for the patient 'culture brokered' or interpreted the health care environment for the patient. The process of culture brokering entailed bridging, linking, or mediating between groups (Jezewski, 1993). Snowball (1996) conducted a hermeneutic phenomenological study whereby nurse participants stressed the importance of the therapeutic relationship as the key to advocacy. The nurse's and the patient's shared common humanity, the cultural environment of care in which the advocacy occurred, and descriptions of reactive and proactive levels of advocacy also were revealed (Snowball, 1996). Reactive advocacy referred to the nurse's description of specific or individual



advocacy. Acting in reactive ways to the immediate needs of patients, who were direct responsibility, or responding to risk type situations, were the predominant modes of advocacy (Snowball, 1996). Proactive advocacy referred to the need for advocacy on a wider scale for a group of patients or for the nurses as a collective (Snowball, 1996). Snowball (1996) found that the nurses did not view the advocate role as an opportunity to gain power but rather as part of a collegiate endeavor, which was undertaken with other health care professionals.

More recent theories of patient advocacy were brought forth by Bu and Jezewski (2007) and Hanks (2008). Bu and Jezewski (2007) attempted to clarify and refine the concept of patient advocacy with the goal of establishing a theoretical basis for guiding practice or research on patient advocacy in nursing. The three core attributes of patient advocacy were identified as safeguarding patients' autonomy, acting on behalf of patients, and championing social justice in the provision of health care (Bu & Jezewski, 2007). The proposed mid-range theory contained the same philosophical ideas as those encompassed within the four advocacy models proposed by Curtin, Gadow, Kohnke, and Fowler (Bu & Jezewski, 2007). Antecedents of patient advocacy occurred at both the macro-social and micro-social level and the consequences of advocacy behaviors were contextually based and could positively or negatively influence patients, other nurses, or the nursing profession (Bu & Jezewski, 2007). Hanks (2008) provided the Sphere of Nursing Advocacy (SNA) model, which was used to explain and depict nursing advocacy on behalf of a patient. The basis for nursing advocacy in the SNA model was formulated from the philosophical works of Curtin, Gadow, and Kohnke. The nurse created a protective, semipermeable shield around the patient, which allowed the patient to self-advocate if emotionally and physically able (Hanks, 2008). The nurse advocated for the patient who was unable to advocate for himself or herself (Hanks, 2008).

**Service user and family perspectives on nursing advocacy.** Few authors in the nursing advocacy literature specifically touched on the service user or family perspective of nursing advocacy (Jugessor & Iles, 2009). The patient's perspective has been noted as important because this subjective experience determines an individual's well-being and quality of life (Morselli, 2000). Findings from the available research suggested that some differences and similarities existed between ways that nurses, and those for whom they provide care, experience nurse advocacy.

Breeding and Turner (2002) found in their qualitative study that patients may not be aware of the nursing advocacy activities. Vaartio, Leino-Kilpi, Salanterä, and Suominen (2006) interviewed both nurses and patients from medical and surgical units for their qualitative study conducted in Finland. Patients defined advocacy both as commonplace in nursing but as going beyond good care (Vaartio et al., 2006). Advocacy was not viewed as a single event, but rather as a process of analysing, counselling, responding, and whistleblowing (Vaartio et al., 2006).

Ward (2013) developed a substantive-level grounded theory that focused on the consumer perspective of patient advocacy with 22 patients and family members from two medical units, the emergency department, and an intensive care unit at a hospital in Hawaii. Falling through the cracks of the system, being heard, receiving information, and participating were the core concepts identified (Ward, 2013). Nurses were often perceived as too busy to be patient advocates and consumers were aware of the interconnectedness between team functioning and quality of care (Ward, 2013). Some consumers viewed anyone involved in their care as a potential advocate, while others believed that only a person not affiliated with the hospital could be a patient advocate. The aspects of care identified by consumers as patient advocacy mirrored competencies and standards of professional nursing practice and Ward (2013)

concluded that no additional training was needed for nurses if patient advocacy was thought to be a metaphor for these competencies. Patient advocacy was thought to be comprised of a different skill set if the purpose of the advocacy was used for meeting unmet needs of patients (Ward, 2013).

Huey, Lefley, Shern, and Wainscott (2007) focused on the topic of involving families in the care treatment of schizophrenia from the perspective of national advocacy. Families shared consumers' desires for greater autonomy and independent functioning (Huey et al., 2007). Families desired treatments focusing on safety, shared decision making through advance directives, and partnerships with primary care providers and trauma informed services (Huey et al., 2007). Advocacy organizations and professionals were called upon to provide public and political pressure to address discrimination and implement social policies that promote well-being (Huey et al., 2007).

Morselli (2000) analysed the role and development of the Mental Health Illness Advocacy Movement in the USA and Europe in the management of the mentally ill until 1999. The collective voice of the Patient Advocacy Organizations was deemed to be greater than any individual voice and over the years patients and families became more informed about their conditions and their rights. At times, this advocacy has resulted in earlier diagnosis, better adherence to treatment, and more positive outcomes (Morselli, 2000). Morselli (2000) stressed that the action of advocacy groups was not sufficient if the groups were not adequately supported by professional health care providers, institutions, and government agencies. An integrated approach between patients, families, health care providers, the pharmaceutical industry, and government agencies was deemed necessary for changes to be made to psychiatric services (Morselli, 2000).

Restall, Cooper, and Kaufert (2011) conducted a study to explore the pathways through which the experiential knowledge of people, who need and use mental health and social housing services, gain access to policymaking. Paradoxically, some service providers found addressing policy issues difficult, yet some citizen-users believed service providers were in a unique position to understand and translate the messages about client experience through the bureaucratic channel (Restall et al., 2011). Service providers felt constrained by translating the ideas and experiences through complex channels, yet citizen-users counted on service providers to translate their experience and influence policy (Restall et al., 2011).

Roe, Weishut, Jaglom, and Rabinowitz (2002) assessed and compared patients' and staff members' attitudes about the rights of hospitalized psychiatric patients at a hospital in Israel in 1996. Significant differences were identified between staff members and patients in four of the six clusters of patients' perceived rights (Roe et al., 2002). Differences between groups were in terms of situations justifying involuntary hospitalization, the use of force or physical restrictions, and confidentiality (Roe et al., 2002). No difference was noted regarding rights of patients to obtain information about their illnesses and treatments and patients' right to refuse treatment (Roe et al., 2002). The main finding seemed to support the stereotype of mental health professionals as authoritarian and not always sensitive to patients' rights (Roe et al., 2002). The difference in attitudes found in this study highlighted the importance of considering multiple perspectives of patients' rights and the extent to which attitudes about patients' rights were associated with each aspect (Roe et al., 2002).

### **Terms Related to Advocacy**

The nursing advocacy literature contained sometimes diverse and conflicting usages of the term advocacy (Falk Rafael, 1995). Some key terms, related concepts, and themes were

closely identified with nurse or patient advocacy such as autonomy, empowerment, and paternalism, which can be difficult to distinguish one from another (O'Connor & Kelly, 2005; Zomorodi & Foley, 2009).

**Autonomy.** Autonomy has been a key concept in understanding advocacy (Cole, Wellard, & Mummery, 2014) and has been associated with respecting the patients' rights to self-determination and information, in addition to respecting the patient's integrity and respect for his or her human rights (Hyland, 2002; Pelto-Piri, Engström, & Engström, 2013). Autonomy has been defined as being in control of one's life (Hyland, 2002).

Cole et al. (2014) suggested that the traditional view of individual autonomy was outdated and misguided in nursing. Instead, the feminist perspective was deemed more relevant within the context of advocacy and nurses' work in clinical settings. Humans were viewed as being social in nature therefore social contexts were deemed to have no influence on a person's autonomy. A feminist perspective of relational autonomy was used to provide the argument that the social context of individuals must be accepted as part of their ability to be autonomous and make autonomous decisions (Cole et al., 2014). Vaartio et al. (2006) suggested that the aim of nursing advocacy was to promote patient empowerment instead of patient autonomy because within empowerment, professional responsibility existed behind patient's choices, while within autonomy, choices were made only by the patient.

**Empowerment.** An individual's empowerment has been identified as necessary for better quality of life services (Morselli, 2000). Falk Rafael (1995) reviewed the concept of empowerment in comparison with advocacy. Empowerment was found to be a process that occurred from within and a distinction was made between the idea that one cannot empower another but rather one only can facilitate another's empowerment (Falk Rafael, 1995). Some

conceptualizations of advocacy were found to be incongruent with the concept of empowerment, whereas existential or human advocacy were deemed to be synchronous (Falk Rafael, 1995). A nurse-client relationship based on a philosophy of existential or human advocacy was thought to facilitate empowerment through assisting the client towards authentic self-determination. Falk Rafael (1995) argued that advocacy described the nurse-client relationship from the perspective of the nurse and empowerment from the perspective of the patient. The centrality of mutuality and the nurse-client relationship to both advocacy and a unitary-transformative approach to caring was thought to be consistent with the conditions under which empowerment could occur (Falk Rafael, 1995). Spence Laschinger, Gilbert, Smith, and Leslie (2010) identified a similar theme when a partnership approach to care was used, and nurses and patients collaborated to identify the necessary information, resources, and support that patients required to optimize their health. Clients must have been active and equal participants in their empowerment and empowerment was an enabling process that enhanced personal control (Falk Rafael, 1995). Stylianos and Kehyayan (2012) suggested that advocacy provided an essential mechanism for empowerment.

**Paternalism.** The concept of paternalism has been in sharp contrast to the concept of empowerment. Paternalism reduced personal control, could be disabling, and discouraged active participation from the patient (Falk Rafael, 1995). However the delineation between advocacy and paternalism was difficult to discern (Zomorodi & Foley, 2009). The failure to obtain consent and to respect refusal was associated with paternalism (Gadow, 1983). Martin (1998) described paternalism as nurses making care decisions based on their assessments of need without considering the patients' wishes. Institutional paternalism of the employer occurred when dependency was created because the institutional system generated this type of

environment (Martin, 1998). The nurse's loyalties may have been with the employer because of the existence of a contract of employment (Martin, 1998). Additionally, language and knowledge were controlled by the doctor and the nurse, and unless these professionals provided clear information the patient could not make informed decisions (Martin, 1998).

Zomorodi and Foley (2009) referred to the ambiguity between the concepts of advocacy and paternalism and concluded that in some instances it was not clear whether advocacy or paternalism was being upheld. Nurses could distinguish the 'thin line' (Zomorodi & Foley, 2009, p. 1749) between advocacy and paternalism by developing communication strategies to eliminate ambiguity and by discussing those concepts at interdisciplinary rounds (Zomorodi & Foley, 2009). Weighing the ethical principles of beneficence and autonomy helped to clarify advocacy and paternalism, and provided a means for discussion for nurses practicing in a variety of settings (Zomorodi & Foley, 2009). Clarifying advocacy versus paternalism was difficult, but strategies such as clarifying information and educating health professionals were initial steps in distinguishing between the two concepts. Truly 'knowing' patients, their life experiences, values, beliefs, and wishes also were deemed essential for advocacy (Zomorodi & Foley, 2009).

Some professionals defended paternalism in health care. Gadow (1983) suggested that professionals were empowered by society to enact parental roles towards patients in order to protect them from harm and act in their best interest particularly when patients' wishes were in contrast to their best interest. Additionally, persons basically intended to act in their best interest but sometimes erred in determining what was their best interest (Gadow 1983). The health professional intervened to prevent a health abusing behavior in accordance with the patient's most fundamental desire not to be harmed in accordance with the individual's 'true self' (Gadow, 1983, p. 63). Gadow (1983) argued that to a certain extent these arguments for

paternalism were plausible and some patients did on occasion knowingly wave their autonomy in achieving certain goals. In mental health contexts, acting with the consent of the patient's 'true self' may have been familiar, where a rational person was assumed to agree with a professional's decision even though the decision may have violated the person's wishes at the time (Gadow, 1983). Patients may have been unaware of infringements to their rights because of the nature of their illnesses, which added to the need for psychiatric nurses to be ethically sensitive (Toda et al., 2014).

**Autonomy and paternalism in psychiatric nursing.** A few authors referred to the concepts of autonomy and paternalism related to nursing in mental health settings. The purpose of the qualitative study conducted by Pelto-Piri (2013) was to describe and analyse statements describing real work situations and ethical reflections made by staff members in relation to three central perspectives in medical ethics: paternalism, autonomy, and reciprocity. The study included 173 staff members, who were involved with patients in seven adult psychiatric and six child and adolescent psychiatric clinics in central Sweden. The participants kept ethical diaries over the course of one week in order to describe ethical considerations related to their work. Pelto-Piri et al. (2013) found that the majority of the statements could be attributed to the perspective of paternalism and several of the statements related to autonomy. Only a few statements could be attributed to reciprocity. Pelto-Piri et al. (2013) concluded that despite a normative trend toward reciprocity in psychiatry throughout the Western world, identifying reciprocity in this study was difficult.

Svedberg, Hällström, and Lützén (2000) attempted to gain an understanding of the meaning that community psychiatric nurses imparted to their everyday interactions with patients in depot neuroleptic treatment situations. A finding from this qualitative research was that



treatment care planning involving both patients and nurses was essential for enhancing patients' autonomy, which was thought to be a precondition for satisfactory interactions. For the nurses in the Svedberg et al. (2000) study, participating in coercive treatment in community care was morally difficult. The descriptions of real experiences disclosed that not only were patients' autonomy and rights for self-determination constrained but so were the nurses' (Svedberg et al., 2000).

Svedberg and Lützén (2001) explored ways that psychiatric nurses perceived patient autonomy in relation to their professional roles in depot clinics. The authors described ways that benevolent attitudes towards patient autonomy motivated the nurses' interventions in relation to ways that they experienced their own autonomy. Svedberg and Lützén (2001) found that psychiatric nurses' experience of their professional authority was related to the organization of the depot treatment. Psychiatric nurses were thought to need more time to develop collaborative relationships with patients in order to help them understand the meaning and benefits of the depot injection (Svedberg & Lützén, 2001).

Abbaszadeh, Borhani, and Motamed-Jahromi (2013) conducted a descriptive study to measure nurses' attitudes towards patient advocacy. Some 27 psychiatric nurses comprised 7% of the sample, in addition to nurses from critical care, and general hospital wards. Although generalizing the findings from this study outside of the confines of southeastern Iran was difficult, the results related to psychiatric nurses were interesting despite representing a low portion of the sample. In addition, the education background or workplace experience of the psychiatric nursing sample in comparison to the other nursing specialities was unclear in the findings of the study. Psychiatric nurses' possessed higher levels of competence and autonomy

related to advocacy than critical care or general hospital nurses in the study (Abbaszadeh et al., 2013).

### **Factors Influencing Nurse Advocacy**

Several factors played a role in the facilitation of nurse advocacy. Level of patient vulnerability (Balwin, 2003; Copp, 1986; Foley et al., 2000; O'Connor & Kelly, 2005) or degree of patient's efforts in expressing his/her wishes (Vaartio, Leino-Kilpi, Suominen, & Puuka, 2009a) were key factors, which influenced nurse advocacy. Nurses' sustained contact and proximity with given patients were argued to play a role in recognizing injustices (Curtin, 1979). The nature and quality of the nurse-patient relationship were significant factors in facilitating nurse advocacy and were acknowledged by multiple authors (Chafey et al., 1998; Foley et al., 2000; Josse-Ekland et al., 2014; MacDonald, 2006; Mallik, 1997b; Negarandeh et al., 2006; O'Connor & Kelly, 2005; Snowball, 1996; Tahan, 2005; Watt, 1997; Zomorodi & Foley, 2009).

The nurse's character traits were considered to be a fundamental influence on patient advocacy (Josse-Ekland et al., 2014; Kubsch, Sternard, Hovarter, & Matzke, 2004; O'Connor & Kelly, 2005). A willingness to care was deemed an essential quality for a nurse to possess for effective advocacy (Sellin, 1995; Baldwin, 2003) and empowered nurses were more likely to empower patients (Arabi, Forough, Cheraghi, & Ghiyasvandian, 2014; Hewitt, 2002; Kohnke, 1982; Spence Laschinger, Gilbert, Smith, & Leslie, 2010; Vaartio et al., 2009a).

More senior nurses and those nurses, who had more work experience, were more likely to advocate (Abbaszadeh et al., 2013; O'Connor & Kelly, 2005; Rainer, 2015). Rainer (2015) suggested that generational differences may have existed between nurses, who were baby boomers, generation X, and millennials, with regard to speaking up. Cultural differences, particularly where English was a second language, may have influenced nursing advocacy. The

nurse's relationship with other health professionals particularly with physicians could be a defining factor, which influenced advocacy (Chafey et al., 1998; Hyland, 2002; MacDonald, 2006; Negarandeh, Oskouie, Ahmadi, Nikraves, & Hallberg, 2006; O'Connor & Kelly, 2005; Young, 2009) and may have been a facilitator or barrier depending on the context (Chafey et al., 1998). The culture of the workplace setting also influenced a nurse's ability to advocate (Josse-Eklund et al., 2014; Rainer, 2015; Snowball, 1996; Young, 2009) and knowing the system (Hellwig et al., 2003; O'Connor & Kelly, 2005) was viewed as being beneficial.

### **Perspectives on Advocacy Education**

The ways in which nurses learned to advocate was a factor influencing the facilitation of this phenomenon in nursing. Learning about advocacy could be haphazard and dependent on the situation (Foley, Minick, & Kee, 2002). Hanks (2007, 2008, 2013) found shortcomings with regards to advocacy education in nursing curricula. Higher education levels affected advocacy activity (Hanks, 2008; Kubsch et al., 2004), although advocacy may have been learned on the job (Choi, Cheung, & Pang, 2013; Foley et al., 2002). Nursing education, which included teaching on nursing ethics, was recommended (Alton & Ersroy, 2003; Kohnke, 1982; MacDonald, 2006; Vaartio et al., 2009a). Skill development related to relationship-building particularly with other health-care providers and knowledge of the systems, as well as ethic of the workplace culture, were thought to equip nurses with specific strategies for the achievement of patient advocacy (MacDonald, 2006). Use of collaborative techniques such as negotiation, mediation, and conflict resolution were recommended (MacDonald, 2006). Additionally, nurses needed to be aware of their ethical duty to advocate and be able to inform patients of their rights (Vaartio et al., 2009a). Foley et al. (2002) found that advocacy values were learned in families, communities, and nursing education even though the process may not have been taught formally. Critical thinking

processes in advocacy (Foley et al., 2002), role modelling, and exposure to stories/narratives and discussions of nursing advocacy were recommended for advocacy education (Foley et al., 2002; Choi et al., 2013; Rainer, 2015).

Rainer (2015) recommended that nurse leaders talked to staff about speaking up, reviewed chain of command policies so that nurses knew their options if facing resistance to their objections, and provided support for staff in all serious incidents. Celebrating the moments of speaking up and recognizing peers, who found their voices, was thought to strengthen the culture of speaking up (Rainer, 2015). Choi et al. (2013) found that team-based learning was an essential factor in facilitating the development of nurses' advocacy role and practices. Nursing education, focused on the role of client advocate and ways to manage the barriers associated with advocacy, was recommended (Hanks, 2007). In a study of community health nursing advocacy, Ezeonwu (2015) identified the need for more knowledge of the legislative/political processes in nursing curricula. Furthermore, nurses were advised to have knowledge of the law if they were adopting such terms as 'informed consent' (Hewitt, 2002). Social justice and social advocacy education for nursing students and practicing nurses at all levels of nursing was viewed as necessary (Hanks, 2013). Training programs should be clear about the limitations that mental health nurses would face when addressing mental health inequalities (Elliott & Masters, 2009).

Nursing education, which focused on the role of client advocate, was recommended (Hanks, 2007). Llewellyn and Northway (2007) found in their UK study that nurses, who received theoretical education, did not feel confident to advocate for their clients living with learning disabilities. Fifty percent of the nurses in Llewellyn and Northway (2007) study had not, or could not, remember receiving formal advocacy education. The nurses believed that advocacy education was appropriate at the pre-registration level but also was needed on an

ongoing basis. Practical advice was desired and the nurses expressed a need for support and training in advocacy related to the UK's Human Rights Act, the Disability Discrimination Act, and specifically for clients in their practice area. Llewellyn and Northway (2007) provided several recommendations concerning nurses' advocacy education for nurses working with individuals with a learning disability. Education at all levels should be provided by nurse educators and by people from a range of services with different advocacy experiences (Llewellyn & Northway, 2007). Theoretical training and practical advice given at a pre-registration level was recommended. At a post-registration level ongoing practical advice within the work context was advised in addition to information about legal issues involving advocacy (Llewellyn & Northway, 2007). Arabi et al. (2014) held similar views and advised that nurses needed to be aware of policy agendas, policy makers, and political backgrounds in addition to advocating for nursing as a profession.

More education was deemed necessary for nurses with regards to accessing independent advocates including how and when to access advocates. Training, related to interactions with citizen advocates should be offered to both nurses and citizen advocates so that they could understand each other's roles (Llewellyn & Northway, 2007). In their study of independent advocates in the UK, Carver and Morrison (2005) echoed these sentiments as being particularly relevant for mental health nurses. Repper and Carter (2011) acknowledged that many challenges were associated with the implementation of peer support workers in the UK and also recommended further training, supervision, and management of all persons involved.

### **Challenges Associated with Nurse Advocacy**

Nurse advocacy has been fraught with dilemmas (Hewitt, 2002) and challenges have been associated with nurses taking on this role. Nurses may have been required to stretch

beyond their comfort zone and be open and vulnerable (McSteen & Peden-McAlpine, 2006) yet the consequences of not advocating may have meant that patient care issues went unresolved (Hanks, 2007).

Hewitt (2002) suggested that nurses should recognize that they do not have a monopoly on ethical decision making and that more suitable candidates for the role of patient advocate may exist. Other health care professionals may claim that it is arrogant and insulting for nurses to have suggested that advocacy was unique to nursing (Hyland, 2002). Mallik (1997b) argued that no single health professional group should act as a watchdog for another professional group. However if one professional group sees itself as more powerful in the decision-making processes and abuses that power, then the patient still may need to be protected. Hospital ethics committees and patient representatives were considered appropriate sources of referral for difficult or adversarial conflicts. However, similar to nurses, the committees and patient representatives may experience the same constraints as hospital employees (Gaylord & Grace, 1995). Ideally, ethics committee members and representatives should not have been employed by the institutions and both hospital employees and health professionals should have been included with particular cases that were being reviewed (Gaylord & Grace, 1995).

Nursing associations in North America have been criticized for withdrawing from advocacy of patient care issues and having assigned that role to individual nurses (Welchman & Griener, 2005). Welchman and Griener (2005) argued that nursing organizations should cease to burden individual nurses with the responsibility of advocacy and rather should restructure ethical codes to reflect patient advocacy as a collective nursing responsibility. Welchman and Griener (2005) suggested that individual nurses still have a role to play in bringing about systemic change through the promotion of patient autonomy.

**Barriers Associated with Nurse Advocacy**

The barriers influencing nurses' abilities to advocate were numerous. Time constraints within workplace organizations (Chafey et al., 1998; Ezeonwu, 2015; Negarandeh et al., 2006), lack of managerial support (Ezeonwu, 2015; Negarandeh et al., 2006), power hierarchies (Chafey et al., 1998; Martin, 1998; Negarandeh et al., 2006), and lack of communication (Negarandeh et al., 2006; Rainer, 2015) were identified as impediments to nursing advocacy. Navigation through multiple community stakeholders with layered interests and agendas could stall advocacy outcomes for community health nurses (Ezeonwu, 2015). Fatigue and lack of motivation (Chafey et al., 1998; Negarandeh et al., 2006) also could obstruct advocacy efforts. Burnout, moral distress, anger, and frustration could be experienced when advocacy attempts were unsuccessful (Austin, Bergum, & Goldberg, 2003; Sundin-Huard & Fahy, 1999). Nurses also ran the risk of strained relationships with colleagues (Chafey et al., 1998; Ezeonwu, 2015; Hanks, 2007; MacDonald, 2006; Negarandeh et al., 2006) or being relocated in an organization (Sundin-Huard & Fahy, 1999). Threats of job loss or retribution were identified as barriers (Hanks, 2007). Professional autonomy was found to be higher for community nurses, while hospital nurses did not feel as liberated from traditional constraints (Chafey et al., 1998).

Negarandeh et al. (2006) described "limited advocacy" (p. 7), when nurses were not able to act at an optimal level, but instead accepted and enacted what they could do. In one qualitative field research study, nurses were found to bend rules for the sake of the patient (Hutchinson, 1990). Many of the actions taken by nurses revealed caring behaviors and their actions were thought to demonstrate belief in the patient's autonomy and the notion of beneficence. Responsible subversion was the construct that was used to describe such behaviors, which could result in positive or negative consequences for the nurse or patients (Hutchinson, 1990). The

process of rule-bending was thought to include nurses bending the rules, new rules becoming accepted, and informal rules becoming formal rules (Hutchinson, 1990). The nurse, who was caught, could be personally affected and as a result decide to become less of a patient advocate with beliefs that the only way to survive was to follow the rules (Hutchinson, 1990).

### **Advocacy, Recovery, and Mental Health**

Advocacy was used to assist the reintegration of persons living with mental illness into all aspects of community life, with the goal of improving quality of life (WHO, 2003). The goals of advocacy and recovery associated with mental illness were similar because they restored individuals' full membership into society at large (Stylianios & Kehyayan, 2012). Advocacy, in the context of mental health has existed across the continuum of care from the hospital to the community (Stylianios & Kehyayan, 2012). Advocacy allowed the individual to have decision-making authority and empowered individuals to play central roles in their care, treatment, rehabilitation, and life choices (Stylianios & Kehyayan, 2012).

Slade et al. (2014) identified ten empirically supported pro-recovery approaches to support a recovery-oriented mental health system. The promotion of peer support workers, advance directives, wellness recovery action planning, illness management and recovery, use of the strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health dialogues were identified as pro-recovery approaches (Slade et al., 2014). Similar themes were identified by Stylianios and Kehyayan (2012) who also pointed out that an advocacy model, which supports a social constructionist view of mental illness, may help provide an understanding of stigma, discrimination, and social marginalization.



Recently, Toda, Sakamoto, Tagaya, Takahashi, and Davis (2014) focused on an exploration of 21 Japanese psychiatric nurses' decisions to intervene as a patient advocate as well as the ethical, cultural, and social implications of the nurses' advocacy interventions. Findings could be compared for similarities and differences from a Western perspective. However the group-centered tendency in Japanese culture seems to pose a dilemma for Japanese psychiatric nurses, who may have a tendency to align with a family's will, rather than the patient's will, which may be perceived as paternalistic when compared to a Western point of view.

### **Nursing Advocacy and Stigma**

In Canada, recognition has grown that some of the most deeply felt stigma and discrimination comes from front-line health care professionals and the MHCC has identified this group as a key anti-stigma target (Arboleda-Flórez & Stuart, 2012; Everett, 2009; MHCC, 2012, 2013). Health care professionals have been expected to be the most supportive of people living with mental illness and the least tolerant of stereotypes, yet professionals have been susceptible to societal acculturation and the same stigmatizing attitudes as the general public (Corbière, Samson, Villoti, & Pelletier, 2012; Hugo, 2001; MHCC, 2012; Schulze, 2007). Those persons, who have experienced mental illness, have said that stigma can be worse than the illness itself (Bates & Stickley, 2012; MHCC, 2012, 2013) and stigma was one of the key barriers to seeking help (MHCC, 2013). Various advocacy group organizations were clear in their desire for immediate change (Everett, 2009).

Psychiatric nurses were not excluded from this phenomenon. Their role, as stigmatizing those persons with mental illness and as being stigmatized by their own association with mental illness, has been documented in the literature (Gouthro, 2009; Halter, 2008; Ross & Goldner,

2009; Verhaege & Bracke, 2012). Gouthro (2009) suggested that nurses must “walk the talk” (p. 674) of stigma reduction. Addressing the stigma associated with psychiatric nursing was proposed to help empower members of the nursing profession to address the stigma of mental illness, while concurrently attending to its issues with stigma, which is thought to provide better patient and system outcomes (Spence Laschinger et al., 2010).

The challenge for psychiatric nurses was in the role as advocate (Ross & Goldner, 2009) and action focused on stigma reduction for this professional group was seldom addressed in research (Bates & Stickley, 2012; Gouthro, 2009; Pinto-Foltz & Logsdon, 2009). Advocacy was identified amongst the six approaches to stigma reduction in addition to education, protest, contact-based education, legislative reform, and stigma self-management (Arboleda-Flórez & Stuart, 2012). In the MHCC’s (2015) *Guidelines for Recovery-Oriented Practice*, advocacy and empowerment were named as one of the three best stigma-reducing strategies, in addition to positive personal contact, and education about the recovery journey. Yet, few anti-stigma approaches were empirically tested and no best practice guidelines were documented for psychiatric nurses to follow (Pinto-Foltz & Logsdon, 2009).

### **Social Justice**

In a recovery-oriented mental health system advocacy has been recognized as key to addressing inequitable living circumstances and unequal conditions that increase the risk of poor health, and negative mental health outcomes that interfere with recovery (MHCC, 2015). Rudnick et al. (2014) viewed social justice, for people with mental illness and experiencing poverty, as being critical for the preservation of individual and collective humanity. Human rights were not bound to a particular society, but were taken to apply across societal and national borders and political contexts (Grace, 2014).

Buettner-Schmidt and Lobo (2011) defined the concept of social justice as “full participation in society and the balancing of benefits and burdens by all citizens, resulting in equitable living and a just ordering of society” (p. 948). The main attributes associated with social justice included: fairness; equity in the distribution of power, resources, and processes that affected the social determinants of health; just institutions, systems, structures, policies, and processes; equity in human development, rights, and sustainability; and sufficiency of well-being (Buettner-Schmidt & Lobo, 2011). Rudnick et al. (2014) explored the perspectives of social justice amongst people living with poverty and mental illness in Ontario and found that self-determination, sufficient and nutritious food, adequate and safe housing, economic sufficiency, meaningful employment, and access to quality services, were the main themes identified by participants to describe their needs. Health and wellness for the participants in this study were impeded by circumstances and structures viewed as punitive, discriminatory, and rigid (Rudnick et al., 2014).

Deinstitutionalization and movement of resources to the community over the last four decades also has been one way in which the social inclusion of individuals living with mental illness has been promoted, although barriers to social equality still existed (Stylianios & Kehyayan, 2012). Pandya (2014) provided an example of advocacy in mental health on a macro-societal level through the development of a movement advocating for consumers and families affected by borderline personality disorder (BPD). Two trends were described as (a) closer ties between advocacy and professional groups and (b) specialization to better address the different needs created by different diagnosis. Through adaptations, specialization, and strong collaborations, the members of the BPD advocacy movement made considerable progress in a short period of time within the USA (Pandya, 2014).

### **Social Justice and Nursing**

The relevance of social justice to nursing was widespread. At an international level, in the ICN *Code of Ethics* (2012), nurses were called upon to advocate for equity and social justice in resource allocation, access to health care, and other social and economic services. National nurse associations were called upon to advocate for safe and healthy environments (ICN, 2012). In Canada, the CNA (2008) identified endeavors that nurses may undertake to address social inequalities as part of ethical practice in their *Code of Ethics for Registered Nurses*. The CNA (2012) documented in the *Position Statement on Mental Health Services* that all health care professionals must seek to resolve social injustice where people, live, work, and play. The RPNC (2010) echoed the sentiments of their nursing partners and advised that psychiatric nurses “respect the inherent worth, right of choice, and dignity of persons” (p.3).

The nursing profession has been identified as well positioned to participate successfully in policy advocacy in order to address inequities, given that this profession is the largest group of health professionals with well-respected nursing organizations at provincial, state, and federal levels (Spenceley, Reutter, & Allen, 2006). Mental health nurses have a key role to play in helping shape existing physical and mental health services (Elliott & Masters, 2009) yet, the matter of social justice is complicated (Rudnick et al., 2014). The causes of the inequalities were thought to be complex and arising from fundamental divisions in society (Elliott & Masters, 2009). The role of the economy in creating social classes, ways that men and women are socially defined, differences between ethnic groups, and the provision of mental health services, were factors that could adversely affect mental health (Elliott & Masters, 2009).

**Challenges Associated with Social Justice Advocacy**

Nurses may face difficulty in mediating between the needs of a particular individual and the needs of a patient population. Therefore gaining an understanding of the nuances associated with human rights and justice has become important for all nurses (Grace, 2014). In advocating for one patient to have his or her needs met, nurses may disadvantage another (Grace, 2014). Health services and nursing bodies may not have been powerful enough to tackle some of the mental health inequalities such as poverty, which required extensive government reform (Elliott & Masters, 2009). Nurses were perceived to participate in advocacy at the societal level in matters of health yet many authors have observed that nursing advocacy at the policy level was all but invisible (Hanks, 2013; Spenceley et al., 2006). At a policy level, a disconnect existed between what nurses were expected to do and what nurses actually did (Spenceley et al., 2006). Challenges from within the nursing discipline, in the practice context, and at the interface of nursing and policy existed to decrease nurses' involvement in social justice activities (Spenceley et al., 2006).

O'Mahony Paquin (2011) suggested that nursing practice was steeped in critical thinking, advocacy, and relational skills at an individual level. The nursing interventions grounded in social justice advocacy presented in nursing literature and ethical codes were thought to provide only general statements about becoming engaged in community organizing, becoming politically involved, reforming institutions, working together to influence legislators, and advocating for health public policy (O'Mahony Paquin, 2011). These broad recommendations were thought not to provide specific information on the means for the individual nurse to work from a social justice perspective (O'Mahony Paquin, 2011).

### **Psychiatric Nurses Can Advocate for Social Justice**

Nurses should address social justice issues that affect their populations (Grace, 2014). On an individual level, psychiatric nurses could include the effects of stigma, poverty, and victimization in patient assessment and treatment planning (Perese, 2007). Individuals living with severe mental illness and poverty could be assisted by psychiatric nurses to ensure access to safe housing, transportation, personal safety, nourishing food, appropriate clothing, and social activities (Perese, 2007). Interventions also may include encouraging a sense of self-identity tied to familial, social, and vocational roles (Perese, 2007). Spenceley et al. (2006) encouraged nurses to participate with their professional organizations and to ask questions about the role and focus of these professional organizations in advocacy at the policy level.

Additionally, the nursing profession may benefit from using the well-developed policy and social science literature about ways to influence policy (Spenceley et al., 2006). Nurses advocating for social justice could look towards the WHO for direction. The WHO (2003) outlined ways to assist policy-makers, planners, advocacy groups representing people with mental illness and their families, and both general and mental health care workers. In their document *Advocacy for Mental Health*, the WHO (2003) offered ways to develop policies and comprehensive strategies for improving the mental health of populations, use existing resources to achieve the greatest possible benefits, provide effective services to those in need, and assist the reintegration of persons living with mental illness into all aspects of community life. The WHO (2003) also provided explanation on the roles of different groups in advocacy, ways that ministries of health can support advocacy, examples of good practice in advocacy, as well as a review of barriers and solutions to supporting advocacy from ministries of health. Not all nurses will be able to become policy experts and provide care but they could identify and articulate

ways that policies affect health on the behalf of patients (Grace, 2014). Patients also could be directed towards professional or advocacy organizations, which can assist individuals to meet their needs (Grace, 2014).

Advanced practice nurses (APNs) have become uniquely positioned to conduct research and articulate the consequences of problematic practices to those persons in charge of policy decisions at either an institutional, local, or societal level (Grace, 2014). APNs may need to be engaged politically at a variety of levels, either individually or collaboratively (Grace, 2014). Additionally, APNs could write letters to newspaper editors to get public attention and raise questions or be members of ethics boards or educate and provide information to grassroots organizations (Grace, 2014).

Elliott and Masters (2009) recommended that services to address mental health inequalities should be offered based on moral or ethical values. Additionally, services should be designed for specific groups and tailored for those individuals, who have been difficult to engage. Improved cultural competency was recommended for nurses and designing services that aim to work with people, who may not suffer from mental health problems, but have a key role supporting those who do, such as informal carers or peer supports (Elliott & Masters, 2009). Collaboration with social welfare, housing, child care, and services outside of the traditional mental health services was advised (Elliott & Masters, 2009).

### **Implications for Research and Psychiatric Nursing Case Management Practice**

Little knowledge existed regarding the advocacy experiences of psychiatric nurses and strikingly few studies have taken place in mental health settings (Juggessor & Iles, 2009; Vaartio & Leino-Kilpi, 2005). The use of hermeneutic phenomenology, as the chosen research method, was used to respond to the need for more descriptive studies related to the experiences of nurse

advocacy (Hanks, 2008; O'Connor & Kelly, 2005). The study of the advocacy experiences of psychiatric nurse case managers working with individuals with severe mental illness provided one context in which the exploration of this phenomenon for psychiatric nursing could begin. Research results may have implications for practice, education, research, and policy related to advocacy. Phenomenological inquiry yielded empirical knowledge in the form of descriptive theory and understanding, which led to action knowledge (Van der Zalm & Bergum, 2000). Deeper understanding and reflection on the practice of advocacy for psychiatric nurse case managers may have allowed nurses to enhance more thoughtful actions and behaviours associated with advocacy in keeping with a recovery-oriented, client-centred system of mental health care. Perhaps individuals living with severe and persistent illness in turn could expect further enriched nursing care, which was empowering and respectful of individual choice.



### **Chapter 3 - Research Design**

Hermeneutic phenomenology was the research design used in this study to give voice to the lived advocacy experiences of psychiatric nurse case managers, who work in an ambulatory care setting with individuals living with severe mental illness. Phenomenology is used to understand the internal meanings or essences of an individual's experience in the lived world by careful description of that experience with the object of trying to understand that experience rather than providing a causal explanation of the experience (van Manen, 1997). Van Manen (1997) suggested that phenomenological research is explicit in an attempt to articulate through the content and form of text, the meanings embedded in lived experience. Phenomenology is used to reflect on practice, which results in knowledge or understanding, which in turn enlightens practice (van Manen, 1997).

Hermeneutic phenomenology is attentive to the philosophies underpinning both hermeneutics and phenomenology (van Manen, 1997). Hermeneutics is the "theory and practice of interpretation" (p. 179) and phenomenology is the "science of a phenomenon" (van Manen, 1997, p. 183). Hermeneutics and phenomenology are human science approaches rooted in philosophy and reflective disciplines (van Manen, 1997). Phenomenological research always begins in the lifeworld and is the study of essences and the meaning of being human (van Manen, 1997). Hermeneutic phenomenology was used as a research method to discover the deeper meaning associated with nurse case managers' advocacy practices through the use of layered reflection and rich descriptive language.

#### **Research Method**

Hermeneutic phenomenology as described by van Manen (1997) was the research method applied to the study. The researcher adhered to ethical principles outlined in the *Tri-*

*Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014). Refer to Appendix A, The Tri-Council Policy Statement Certificate. The researcher's role, research questions, hermeneutic phenomenological steps, participant selection and research field are described in detail below. The manner in which data were generated, treated, analyzed was also reviewed.

### **Researcher's role**

The researcher is a registered psychiatric nurse currently employed as a Clinical Nurse Specialist (CNS) for the Mental Health Program at a large urban facility in a city on the Canadian Prairies. The researcher's main function as CNS is to improve outcomes in patient care practices through the use of scholarship, collaboration, and empowerment. Previous roles of professional practice have included acute care psychiatric nurse, mental health consult liaison nurse in a general hospital setting, and nurse case management in an ambulatory care setting for adults living with a severe and persistent mental illness. Educational preparation of the researcher includes a Bachelor of Science in Psychiatric Nursing and current enrollment in the Master of Psychiatric Nursing program at Brandon University.

The process of conducting research guided by Heidegger's phenomenological approach requires that the researcher engage in interpretive activities whereby the descriptions given by the participants are accepted and valued as their reality and understanding of the phenomenon (Mackey, 2005). The researcher in the hermeneutic interview gathers and reflects on lived experience in collaboration with the participants (van Manen, 1997). The researcher and participants for this study searched for the meaning embedded in the practices, feelings, and thoughts associated with nurse advocacy, which was shared and co-constructed through language

(van Manen, 2007; Wilson, 2014). Interpretation and understanding exists in a circular relationship between the researcher and participant characterized as the ‘hermeneutic circle’ (Converse, 2012; Wilson, 2014). Creating a phenomenological text is the object of the research process (van Manen, 1997) and the researcher applies a cycle of reading, reflective writing, and interpretation (Lavery, 2003).

A vital part of ensuring rigour in qualitative inquiry is an awareness of the reciprocal influence of participants and researcher on the process and outcome of the research (Jootun, McGhee, & Marland, 2009). The researcher is considered inseparable from the assumptions and preconceptions about the phenomenon of study (de Witt & Ploeg, 2006; van Manen, 1997). The researcher acknowledged and examined her own influence on the qualitative inquiry through an ongoing process of self-reflection throughout all stages of the research. This practice of reflexivity enhances the quality of the research (Streubert & Carpenter, 2011). The pre-understandings, suppositions, assumptions, and scientific knowledge associated with the researcher’s previous experiences as a psychiatric nurse case manager could predispose the researcher to analyze her own personal beliefs as opposed to the participants. Reduction was utilized as the technique to reduce the influence of the researcher’s subjective feelings, preferences, inclinations, and expectations that would prevent her from understanding the lived experiences of others (van Manen, 1997). Reduction involved the awakening to a sense of wonder and mysteriousness about the psychiatric nurse case managers’ experiences with advocacy. In reduction the researcher strives to put aside her beliefs and make her understandings, beliefs, biases, assumptions, presuppositions, and theories explicit in order to remain open to the data as revealed by the informant, although the researcher can never eliminate her influence completely (Streubert & Carpenter, 2011; van Manen, 1997).

**Research questions**

Participants were asked broad, general questions in interviews conducted with hermeneutic phenomenological methodology (Creswell, 2013). Open-ended questions allowed the researcher to follow the participants' leads and ask clarifying questions about their lived experiences (Streubert & Carpenter, 2011). The participants reflectively recalled their experiences with prompting from the researcher in order to bring to light the descriptions of the experience (Converse, 2012).

Hermeneutic phenomenology was utilized to answer the research question: What are the advocacy experiences of psychiatric nurse case managers, who work in an ambulatory care setting with adults living with severe mental illness? Participants were asked to describe what advocacy meant to them; what their experience advocating for individuals living with a severe and persistent mental illness in their current role has been; what their experience has been related to the factors that helped them facilitate advocacy; what their experience has been when a decision not to advocate was made; and what advice or tips they would give to other nurse case managers about advocacy. Refer to Appendix B, the Interview Guide.

**Hermeneutic phenomenological steps**

Van Manen (1997) described the dynamic interplay of six research activities, which were involved in hermeneutic phenomenology and were used to explore the lived advocacy experiences of psychiatric nurse case managers, who provide nursing care to individuals living with severe mental illness in the context of ambulatory care. The procedural steps involved in hermeneutic phenomenological research include:

- (1) turning to a phenomenon which seriously interests us and commits us to the world;
- (2) investigating experience as we live it rather than as we conceptualize it;

- (3) reflecting on the essential themes which characterize the phenomenon;
- (4) describing the phenomenon through the art of writing and rewriting;
- (5) maintaining a strong and oriented pedagogical relation to the phenomenon;
- (6) balancing the research context by considering parts and whole (van Manen, 1997, p. 30-31).

### **Participant selection and research field**

Purposeful snowball sampling was used to invite participants to the study. Purposive sampling is used most commonly in phenomenological inquiry and allows for the selection of individuals based on their knowledge of a phenomenon for the purpose of sharing their knowledge (Streubert & Carpenter, 2011). The participant inclusion criteria was limited to active registration as a Registered Nurse (RN) or Registered Psychiatric Nurse (RPN) in addition to current practice in an ambulatory care setting, as a case manager providing nursing care to adults living with a serious and persistent mental illness. Six psychiatric nurse case managers participated in the study. Recruitment took place in a large urban city on the Canadian Prairies. Being a psychiatric nurse case manager from rural settings was an exclusion criterion for the study as mental health care provision and resources in rural communities differs from services and resources available in an urban setting.

A letter of invitation was provided to three psychiatric nurse case managers, who were recruited based upon the researcher's professional knowledge of and experience with these nurses and in keeping with the inclusion criteria for the study. Refer to Appendix C, Letter of Invitation. Each participant was asked to suggest at least three additional participants, who had experienced the phenomenon and who met the inclusion criteria. The researcher provided a letter of invitation to the additional participants. A total of six potential individuals were

approached and invited to participate in the study. Each individual agreed to participate and each participant was interviewed once.

The goal of phenomenological inquiry is to understand the meaning of an experience of a phenomenon, not to generalize the information, therefore the number of participants can be reasonably small (Converse, 2012; Kleiman, 2004; Streubert & Carpenter, 2011). The goal of this study was to better understand the psychiatric nurse case managers' advocacy experiences when working with individuals living with severe mental illness. Therefore participants were recruited until the data requirements were met and meaningful analysis could occur. The information collected in the six interviews was deemed sufficient for the researcher to conduct meaningful analysis. The researcher did not approach any potential participants prior to the commencement of study. Following ethical approval from Brandon University Research Ethics Committee (BUREC) the researcher began participant selection based on the research process and inclusion criteria.

The first participant was interviewed in May 2016 and the final participant was interviewed in July 2016. Each interview for this study occurred in a private setting of the participant's choosing. Interviews were conducted in an environment that was comfortable for the participant and allowed the researcher to enter into a relationship of dialogical openness (Kleiman, 2004).

### **Ethical Considerations**

The proposed research was submitted to BUREC at Brandon University for approval. Refer to Appendix D, BUREC Ethics Certificate. Deception, coercion, leading questions, or other forms of persuasion did not occur in this study. Incentives were not provided. Unforeseen

events were to be openly reported to the thesis supervisor, Dr. Fran Racher and BUREC. No unforeseen events occurred.

Participants were made aware of the purpose of the research, ways that confidentiality was to be maintained, and strategies for disseminating the results. Informed consent was obtained from participants prior to involvement and throughout the research process. Participants were provided with a copy of the consent form (Appendix E). The form was reviewed with participants. Participation in this study was voluntary and participants were informed that they could withdraw from the study at any time without consequence. The participants were informed that the relationship with the researcher or Brandon University would be not affected, if a participant chose to withdraw from the study. A copy of the consent form was provided for the participant's records. Participants were invited to ask any questions that they may have had about the study and/or interview before signing the form and these questions were answered by the researcher. When written consent was obtained, the consent form was kept separate from participants' contact information and other information included on the demographic data collection tool (Appendix F) and in field notes (Appendix G). The separation of identifying information from coded data was fundamental to safeguarding participant privacy and confidentiality.

Some of the participants were former colleagues of the researcher however, no positions have been held by the researcher that entailed any supervisory duties or power over any participants for this study. Research was not conducted during paid employed time and this research was in no way affiliated with the researcher's employment. The health centre was not involved in this research study and employment was not affected in any way regardless of the decision a nurse made regarding participation in this study.

Participants were informed that their names would not appear in any report or publication of the research. Data (e.g., interview recordings, transcripts of interviews) were stored safely in a locked cabinet and on a password-protected computer and only the researcher and the thesis advisor had access to the data. Participants' identities were protected by use of pseudonyms and only the researcher was aware of the participants' identities. When interviews were transcribed, names were removed and efforts were made to remove any information from the interview that could make a participant identifiable. Participants were informed that no identifying information would be included in any presentations or publications arising from the study. Paper copies will be shredded and electronic files will be deleted following the thesis defense and dissemination of research findings. Data will not be used outside the scope of consent.

A transcriptionist was hired following a conversation regarding the importance of confidentiality and ways that confidentiality will be maintained. The transcriptionist signed a confidentiality agreement (Appendix H) prior to receiving data. The transcriptionist was instructed to delete all electronic files following completion of the data analysis process.

### **Data Generation and Treatment**

Face-to-face, semi-structured individual interviews using open-ended questions were carried out at private locations and times agreed upon by the researcher and participants. These interviews were the primary source of data collection. These interviews lasted approximately 40 to 60 minutes and were audio-taped and transcribed verbatim. Kleiman (2004) discussed ways that face-to-face interviews allowed the researcher to get experience of the nuances of the participants' communication, which can be conveyed through such things as facial expressions, silences, or gestures. Immediately following the interview, the researcher engaged in a process of reflection and considered questions prompted from the field notes guide (Appendix F). Field



notes are an important part of data collection and analysis (Streubert & Carpenter, 2011) and allowed the researcher to make note of the participants' facial expressions and gestures as well as other attributes.

The audio-taped interviews were transcribed verbatim by a paid transcriptionist. The transcriptions were reviewed by the researcher for accuracy. All computerized data including audio-files were password protected, saved on a flash drive, and accessed only by the researcher, thesis advisor, and transcriber. The flash drive and written notes were stored under lock and key at the researcher's place of residence. Computerized data and notes will be destroyed following the thesis defense and dissemination of the research findings.

### **Data Analysis**

The researcher's reflective experiences of the participant's descriptions come to life during data analysis (Kleiman, 2004). Data analysis in qualitative research begins with data collection (Streubert & Carpenter, 2011). Following each interview, the researcher engaged in a process of phenomenological reflection. The researcher continuously reviewed notes and transcriptions in a cyclical nature to discover additional questions or to offer descriptions in order to discover meaning. The researcher interacted with the data by highlighting and underlining sections of the transcripts that contained significant statements, sentences, or quotes, which provided an understanding of ways that the participants experienced the phenomenon. Through a circular process of writing and re-writing the researcher was able to clarify, promote reflection, and allow for deeper meaning to occur. The researcher then developed clusters of meaning from these significant statements into themes. Themes in phenomenology may be understood as the structures of experience (van Manen, 1997). The researcher then compared one transcript to the next and noted that certain experiential themes recurred. Next, the researcher gave an

elaboration of the findings and described the essential meanings by defining the meanings and providing examples from the raw data. The researcher critically analyzed her work throughout the phenomenological analysis in order to verifying that the detailed descriptions were obtained from the participants, essential meanings were discovered, a structure was articulated, and the results were verified in the raw data in order to enhance the trustworthiness and authenticity of the data. The researcher also ensured that phenomenological reduction had occurred concurrently throughout the research process. The researcher made a concerted effort to address personal biases, assumptions, and presuppositions and set aside these beliefs in all phases of the research and analysis in order to understand the psychiatric nurse case managers' lived experience of advocacy. Credibility is added to the study when the researcher tries to understand ways that one's own values and views might influence study findings through the process of reflexivity (Jootun, McGhee, & Marland, 2009), which was a process undertaken for this study.

The rich descriptions of the psychiatric nurse case managers' advocacy experiences are shared in the following chapter. In this study, six overall themes emerged from the texts of the participant interviews and are depicted in Chapter Four, the research findings.

## **Chapter 4 - Findings**

The research findings in this study included demographic information, information reported by the nurse participants, and observations made by the researcher during the interviews. Field notes were used by the researcher to document observations following the interviews, which provided further information for the data analysis. The nurses' demographic information collected included: their ages, professional affiliation, nursing education level, total years of nursing practice, total years of non-psychiatric nursing practice, total years of psychiatric nursing practice, areas of employment in mental health, and length of time employed as a psychiatric nurse case manager. The themes generated from the information collected included: embarking on a journey, resources for the journey, travelling solo and with others, the journeys and time, types of journeys, and collective journeys.

### **Participants**

The six participants in this study were all women ranging from 36 to 61 years of age with the average age being 51 years. All of the individuals approached to partake in this study met the inclusion criteria and agreed to participate. Three of the participants held active registration as Registered Nurses (RNs) and three as Registered Psychiatric Nurses (RPNs). Each participant worked in an ambulatory care setting in a large city on the Canadian Prairies. All of the participants were employed in the role of psychiatric nurse case manager and worked with individuals living with severe and persistent mental illness. The total number of years that participants worked in their current role as psychiatric nurse case managers ranged from 1 year to 16 years with the average being 7 years.

Participants varied in terms of education background and prior nursing experience. All of the participants began their nursing careers with formal training and registration in psychiatric

nursing through either diploma or baccalaureate preparation. Three of these individuals had allowed their psychiatric nursing registration to lapse after pursuing additional education, which then permitted them to register with RN status. Five of the six participants held one or two baccalaureate degrees including nursing, psychiatric nursing, psychology, or developmental studies.

The participants of this study spent almost their entire nursing careers in various roles, or working with different specialty populations, within mental health. The total number of years that participants spent in nursing practice ranged from 10 to 30.5 years with an average of 24.3 years. The total average amount of time spent working in psychiatric nursing practice was 23.6 years. Four of the participants had never held nursing employment outside of the field of mental health. One participant had worked with children living with developmental delays and another participant had worked in the community with individuals living with a disability, which was practice that she considered to be outside of mental health. Several of the participants had common past psychiatric nursing experiences, which included work in acute inpatient care, psychiatric emergency, and instructional teaching for nursing students. The participants reported other past areas of employment in mental health, which included work in the community, forensics, palliative care, consult liaison, short-term psychotherapy, administration of depot medications, and northern nursing. Some of the participants reported having worked in the past with individuals living with different mental health diagnosis including eating disorders, mood disorders, and anxiety related disorders.

All of the participants displayed genuine curiosity related to the research process and asked questions about the study methodology and method. They all expressed interest in the subject matter and shared that they were looking forward to hearing about the results of the

study. The six participants were assigned the following pseudonyms to protect their identities: Kelly, Brenda, Teresa, Michelle, Sara, and Robin.

### **The People Involved in the Nurses' Practice**

The nurses primarily spoke about their advocacy activities, as being focused on the individuals involved in their practice, which provided most of the context for this study. Advocacy pertaining to a shared cause, on a larger more macro-level scale, was minimally mentioned by the nurses. Advocacy was not limited just to speaking on behalf of individuals but also was associated with family members, significant others, or health care providers attached to the individuals in the nurses' practices.

People were described as being at different places along their roads to recovery. Life circumstances varied and some individuals were depicted as being profoundly impacted by their illnesses and circumstances. Formal support for managing various activities of daily living was often needed. Many of the people in the nurses' practices lived in supportive housing environments, group homes, and rooming houses. Others, who were more deeply impacted, were homeless. Some of the people were described as requiring additional support from community mental health or home care services, while others were supported by their families or significant others. The nurses also described working with people, who were farther along in their recovery journey and struggled only in certain areas of their lives such as employment, education, or relationships.

### **Researcher's Influence**

The researcher engaged in a process of self-appraisal and acknowledges ways that previous studies and experience as a psychiatric nurse case manager influenced her interest in the research topic. Drawing on previous experience in this role allowed the researcher greater

understanding of the information and details shared by the nurses. Deeper meaning was added to the nurses' descriptions through the researcher's insider view of the role. For example, the researcher understood various nuances associated with the different acronyms, abbreviations, and processes that the nurses' used and described in their interviews. The researcher's insider position also meant engaging in a process of constantly being alert and rigorously checking and re-checking to ensure that the analysis remained true to the data.

The researcher also acknowledges that conducting this research project is itself a form of advocacy. The values inherent to a recovery-oriented philosophy of mental health care are important to the researcher and have some influence on this study. A recovery-oriented philosophy refers to the idea that one can live a satisfying, hopeful, and contributing life, even when mental health problems and mental illnesses cause ongoing limitations (MHCC, 2012, 2013). A recovery-oriented philosophical position in the context of mental health care also refers to the idea that each person is unique, with the right to determine his or her path toward mental health and wellbeing (MHCC, 2012, 2013). The researcher attempted to use written language that reflected the values and beliefs associated with a recovery-oriented philosophy. For example, the researcher used the term individual, except when a nurse was directly quoted, rather than the terms patient or client. Avoiding these two terms was thought to be in keeping with a person-first principle of recovery.

The nurses in this study were protective of the identities of the people involved in their practices and did not use names in any of their examples. It should be noted that the researcher applied pseudonyms to the men and women, mentioned by the nurses for two primary reasons. Applying a pseudonym allowed for ease of writing and also was thought to remind the reader that the individuals in the nurses' practice were more than the struggles they lived with and the

diagnoses they were given. The researcher immediately followed these names with an asterisk to denote where a pseudonym had been applied. For example, the pseudonym Irene\* was applied to one of the woman in the examples that one of the participants shared.

### **A Journey as a Metaphor for Advocacy**

All of the nurses involved in this study talked about ways that they strove to engage in nursing practice, which was reflective of a recovery-oriented philosophy of mental health care. They displayed understanding that recovery associated with severe and persistent mental illness was a complex and a deeply personal process for the individuals involved in their practice, with each person's destination and path towards recovery being unique. It became clear as the researcher read and reflected on the transcribed interviews that advocacy, practised in the context of the psychiatric nurse case managers' role, mirrored the concept of recovery in uniqueness to the person and situation. Brenda provided the following explanation, which helped illustrate this point.

*“And it’s something that you can’t just, you know, blanket statement, this is what advocacy is in this job. It’s very individual and it really depends on the patient’s needs at that time. And it changes, you know, from day to day. And every day I never know what I’m going to be doing for each of my patients so again...be open minded and just be patient first, right?”*

Key words and phrases were repeated by some of the nurses and stood out to the researcher in the written text. Visual images of individuals embarking on a voyage, walking along a path, or being on a train journey were evoked by terms used by the participants such as navigation, time, preparation, readiness, and steps.

The researcher visualized the nurses and individuals in their practices as walking along separate but distinctly parallel paths. The nurse's journey was unique and consisted of her travelling along one path throughout her career. Individuals, together with their families, and loved ones, travelled along other paths, as part of their own unique journeys. The nurse

throughout her career would join individuals and their family members, on their journeys, at different points in time. The ways to proceed towards the destination for the individual's journey were decided together. The destination was decided by the person and reflected that person's goals for recovery. The individual was not always aware, that the nurse was present and travelling along with him or her, because the nurse's advocacy activities were not always known to others. Brenda explained,

*“But lots of times, when I advocate, lots of time the patients aren't even aware that I'm doing these behind the scenes advocating. So it's not like I'm going to say, I'll call them up and like did you just know what I went through to get you a bus pass? Doesn't matter. Right? It's, the goal is to get the bus pass and doesn't matter. They don't really care how I do it.”*

Regardless, of whether the nurse's advocacy activities were known, or unknown to others, the nurse worked towards engaging in advocacy activities that assisted the person towards achieving his or her own goals. The researcher began to understand the nurses' advocacy experiences through the use of this metaphorical journey. The imagery associated with a journey was used to help organize the various themes and sub-themes. In total, six primary themes emerged from the nurses' experiences with advocacy: embarking on a journey, resources for the journey, travelling solo and with others, the journey and time, types of journeys, and collective journeys. Sub-themes were embedded within each of these primary themes, which further enriched the understanding associated with the psychiatric nurse case managers' advocacy experiences.

### **Embarking On a Journey**

Embarking on an advocacy journey was a complex process for the participants of this study and involved a confluence of factors. The nurses depicted advocacy partly as being human responses related to the ways they viewed themselves to be as people. Sometimes the nurses were compelled to advocate because there was no one else in an individual's life to help. Partly,



embarking on an advocacy journey with another was felt to be a professional responsibility or part of one's job. Advocacy was not always an easy process and could be a difficult experience for the nurses. The nurse's ability to embark on an advocacy journey with an individual also was influenced by the need to promote a person's autonomy and right to self-determination.

### **Being human.**

There was a genuine sense of humanness about the ways that the nurses referred to their advocacy activities, which was revealed through their body language and in their facial expressions, in addition to their spoken words. The researcher was given the impression that embarking on an advocacy journey extended above and beyond the confines of the nurses' professional roles. Nurses were prompted to act as part of the greater good that humans do for one another. Teresa felt that she was in a position to help others get back on their feet and so this realization meant doing what she deemed as the right thing.

*"...I think as long as you're doing the right thing. You've got to think about doing the right thing. What you would want for your family. Yeah. What you would want for yourself."*

The researcher was struck overall by the humility and self-effacing quality in which all the nurses detailed their advocacy experiences. They all spoke with compassion about individuals, with whom they worked, using respectful and empathic tones. This humanness was displayed by Robin as she matter-of-factly revealed that she had handed over pieces of her lunch to a woman who had shown up to Robin's office hungry. Teresa talked about the ways that she had helped one individual through the process of purchasing a walking cane. Sara mentioned that she had helped a father work through the grief of losing a son. Michelle revealed that she naturally speaks up to her friends when they make misinformed comments about people with the lived experience of mental illness. Brenda and Kelly displayed a sense of compassion in the ways that they talked about looking out for people, who were marginalized in the community.

The nurses revealed a mixture of human emotions, which were observed through their body language and facial expressions. All of the nurses either smiled or lightly chuckled at varying points during the interviews, as if to emphasize certain points or to make a serious situation seem more manageable. For example, the nurses chuckled when discussing the amount of time they spent conducting advocacy activities or in their volume of paper work. Three of the nurses displayed a sense of humour about themselves. For example, one nurse chuckled as she described rummaging through a large refuse bin in order to help a man retrieve his lost identification.

The researcher thought that the most impassioned responses came from the nurses when they were providing examples of situations that they considered to be unjust. Some nurses used more serious facial expression and stronger voice inflection as they detailed these particular experiences. More provocative language was used to impart to the researcher their feelings about the injustices associated with the subject matter. The nurses used terms like “anger”, “shitty”, or “frustration” to highlight their emotions surrounding these themes. The opposite was also observed. A sense of pride and accomplishment was expressed when the nurses explained ways that they successfully navigated challenging situations in order to help people get what they wanted or needed. One nurse became misty-eyed when she talked about her satisfaction when she successfully advocated and helped one individual. Clearly the issues these nurses spoke about mattered to the nurses and their thoughts, feelings, and expressions reflected the humanness attached to their experiences.

### ***Who I am.***

Intertwined with the theme of being human were the ways that the nurses perceived themselves to be as individuals. Four of the six nurses explained that acting as an advocate

partly was prompted by self-reflection and whom they felt they were as people. Michelle and Teresa thought the ability to advocate was part of their natures and was a quality they each possessed. Brenda characterized herself as persistent and assertive.

*“Because I’m one of these people that will find the answer no matter how long it takes. That’s just me, my personality....I will just continue to keep calling and um, figuring it out”.*

Kelly also believed that advocacy was a strong part of who she was as a person and described advocacy as having meaning in both her personal and professional life. She expressed a great sense of pride in being an advocate for a family member living with a disability. Michelle talked about the importance of teaching her children about mental illness and educated them about mental illness when opportunities arose.

**When there is no one else.**

All of the nurses spoke of working with some individuals, who were socially isolated or estranged from natural supports such as family members or significant others. Individuals in the nurses’ care also could be isolated from other health care or community service providers, who could advocate on the person’s behalf. In one way or another, all of the nurses spoke about ways that being the sole source of support for people influenced their advocacy activities. Michelle shared a common viewpoint that was repeated by the nurses throughout all the interviews,

*“...I mean there’s some patients I’m their only person in their life.”*

Three nurses discussed ways that they understood that sometimes more suitable candidates may be available to act as the person’s advocate. Michelle stated,

*“And, I’ll, like you would look at the patient’s supports too. Do they have people in the community that could support them with doing things?”*

All of the nurses believed in the importance of encouraging individuals to increase their sphere of support. Sara explained,

*".... And our goal really is to give them resources or contacts in the community that are going to be helpful for them long term. And sometimes there are other people here, like occupational therapists who help us....now they have a second person, a third person here. And they're not just relying on me. And that part of that is helping them successfully move to another part of, or take it outside of us."*

### **Part of my job.**

Advocacy was not just a human response for the psychiatric nurse case managers. All of the nurses experienced advocacy as a professional responsibility, which was incorporated into their everyday roles as psychiatric nurse case managers. This expectation was a primary catalyst in the nurses' ability to embark on an advocacy journey and was stated by all of them. Michelle explained,

*"...I think that's a huge part of my job....It's not getting in the way of anything or taking away from anything else. That's what I'm here to do".*

Brenda also felt quite strongly that advocacy was part of the role.

*"And it's kind of my job to, um, keep them well in the community. To advocate for them. To look out for them. To help them meet their needs. Um. To be the voice, you know, that they maybe aren't able to, to be. And, um, to know resources that again they might not know that are available to them. And helping them, um, through crisis. To, um, and then even just simple things. Just ADL's."*

Robin shared similar thoughts,

*"Every time you come across a new form, to me filling out paperwork and helping people in that way, it's part of the job..."*

Kelly explained that advocacy was so inherent to her role as a nurse that she was not always consciously aware of when she was advocating. Kelly stated,

*"I think it's a strong part of my nursing career. Um. And I think it's something that, you know, we don't even think about, we just, it's built in and we do it every day....It's just sort of something that you, you know it's built into my daily work routine so I really don't really think about it. I just do it."*

Sarah suspected that she has always advocated as a nurse. She believed advocacy was intrinsic to her role as a psychiatric nurse case manager and involved,

*“...just really basic nursing stuff around trust and availability...”.*

**A difficult experience.**

Advocacy was not always simple for these nurses and at times they experienced the necessity to decline requests made to them by individuals. Kelly stated,

*“Sometimes it [advocacy] can be an easy peasy experience. And sometimes it’s really difficult...”.*

Teresa talked about the importance of trusting and giving people the benefit of the doubt. Unfortunately, occasional circumstances existed whereby the nurses were asked to carry out tasks that could have serious consequences. Two nurses recalled being asked to make fraudulent claims to social services by individuals attempting to take advantage of that system. For example, one nurse talked about the practice of “double-dipping” in the context of being asked to advocate for additional transportation allowances from social services after the individual had chosen to sell his bus pass, which had been provided to him. Robin spoke about individuals, who were unable to accept responsibility for certain situations, and being asked to advocate with the goal of getting the individuals out of these situations. The nurses were not prepared to act on the individuals’ behalves if they believed that the persons were attempting to have the nurse save them from accepting responsibility for their actions. The nurses were not comfortable with the idea of refusing a request but rather they preferred to teach, discuss their point of view with the person, and explore other alternatives. Brenda explained that other options usually existed and should be considered to help a person.

Teresa was clear in saying that the vast majority of the people whom she saw in her practice were sincere and wanted help from the service that she was providing. A couple of the nurses recalled being involved in situations with individuals, who were somewhat manipulative and had displayed antisocial type tendencies. Teresa saw one gentleman whom she discovered

was mainly interested in compelling her to advocate for Tylenol 3 prescriptions for him without having any clear clinical indication for the medication. In this situation, Teresa thought that the man had tried to take advantage of her and she was not prepared to advocate for the analgesics.

*“...I think he was just trying to get his needs met to be honest. I feel he was just, that was the way he knows how to get things done. And, um I didn’t take it personally. I just recognized that...for whatever reason, he’s not ready to, um, to work on the stuff that needs to be worked on...”*

### **Promoting autonomy and avoiding paternalism.**

Sara remarked that a great challenge in the role was to avoid having people, for whom they provided care, become dependent on the psychiatric nurse case manager and inspiring people to be the central figure in managing their own illnesses. All of the nurses were clear that they valued and respected the person’s autonomy and right to self-determination, which also influenced the nurses’ ability to embark on a journey. The inability to act on a person’s behalf could depend on the nurse’s assessment of the wellbeing of the person and where the person might be in his or her recovery trajectory. Sara explained that while an individual may be independent or autonomous in one area of life, he or she may require the support of the nurse or someone else in another area of life. Sara and Kelly explained that having a detailed sense of person’s history was a key component to advocacy, which helped them to distinguish the life areas where a person may require help. The nurses described some people coming to their practice as quite ill and being unable to acquire basic needs independently, who sometimes required that the nurse do more for them in the beginning of the relationship.

Sara explained that advocacy activities changed as people recovered and a shift towards people acting independently and advocating on their own behalf occurs as time moves on. Sara stressed the importance of not acting in a paternalistic manner and overtaking a person’s ability to accomplish his or her own task. Brenda reiterated this point and emphasized that she

encouraged others to act on their own behalves as much as possible. Michelle talked about people making requests in the context of being very ill and her need to weigh the risk and benefits of the requests. She was thoughtful about considering whether or not the consequences of immediately responding to a request could do more harm to a person. Michelle explained that sometimes people change their minds as they feel healthier and a proposed idea might be better to revisit at a later time. Teresa believed that her role was to empower others by providing people with some direction and support so that they were able to find their own way. Teresa used the metaphor of fishing to make the same point as the other nurses in the study. She said the idea is to teach people ways to fish as opposed to simply giving people the fish. Teresa stated,

*“Well my, my hope is that it’s not something that you need to keep people, helping people over and over again. It’s just until they’re able to manage things on their own...So it’s not, it’s not that I want to take people’s, uh, responsibility or their abilities away. But being able to just sort of guide the process until they can take over again themselves.”*

Sara has had experience with people who were genuinely without hope in the context of being very ill. For example, Sara talked about working with people, who were hopeless about returning to work, and in that context asked Sara to support applications for long-term disability. Sara said that she advocated differently when people were hopeless about their ability to return to work. Advocating differently involved having discussions with individuals so they understood the meaning or consequences of not working again. Sara believed that the option to not work was appropriate for some individuals depending on their level of impairment and other factors. Overall, Sara’s experience was that with time, treatment, and support, individuals started to believe in themselves again. Subsequently, more discussions ensued and more work happened with people to provide them with necessary information and skills so that they could begin to take the necessary steps towards their longer-term goals such as returning to work or school.

Robin expressed a similar theme. Robin explored with individuals the factors that might be stopping them from acting on their own behalves when she believed they were well enough to take on particular tasks. Robin recognized that she did not always have the right information and tried to discern the barriers and rationale that might be important for the persons to be able to act on their own behalves. The issue might simply be access to a phone but sometimes the issue could be internal to the individual and related to anxiety, or a lack of self-confidence. Regardless, Robin worked with people to help them problem solve and made an effort not to project herself as a parental figure.

*“And that’s not the purpose of the work that we do or the role that we have. Uh, so the role part of advocacy is helping people to recover that sense of autonomy. A sense of wellbeing. All those steps to that.”*

Robin shared her belief that recovery from mental illness was partly about taking control of one’s own life and responsibility for managing one’s illness. She felt that her role was to help guide and support people through that process.

*“So if I just take over and do it for you, I’ll get it done way faster but what are you getting out of that? What are you learning? What skills are you developing? What’s the point? There is none.”*

A couple of nurses commented on working with individuals, who held differing beliefs than their own.

*“You have to have a sense...that you’re working together for meaning and purpose. And it is to help guide or move someone along a path that they’ve chosen...not you.”*

Kelly explained the difficulty in watching individuals make mistakes or choices that might risk their wellbeing. Kelly worked with a man, who had a long-standing habit of digging for items in large dumpster bins, and despite concerted effort to support this man, he continued. Kelly did not agree with this man’s practice of digging through dumpsters, but she knew that she had to respect his decisions around this activity. Kelly expounded on her belief that her role was



to find a balance between respecting this man's choice to dig through the dumpster bins and finding an ongoing way to inform him of the associated health hazards associated with this practice.

Certain life necessities or circumstances required the voice of the nurse or treatment team irrespective of a person's choice. For example, a person might require official documentation confirming a person's diagnosis for insurance purposes or social assistance. The consequence of not having this documentation completed could result in the loss of a person's livelihood.

Maintaining safety of the person was another circumstance where the nurses intervened irrespective of a person's choice in a given moment. The nurses stressed the importance of respecting the choices that people made about their lives. However, they also spoke of needing to intervene during times when people were assessed as being at risk to harm themselves or others by virtue of their mental illnesses. Kelly intervened by advocating to the psychiatrist for admissions to hospital or the crisis unit for people at immediate risk to themselves or others. Kelly deemed clearly articulating to the psychiatrist, why the person might be at risk and why hospitalization might be beneficial for the person, to be important. Teresa shared her opinion about involuntary mental health practices.

*"...I think that it's sometimes necessary when people don't have those, that judgement. They're not aware of the impact of their illness on them. And I think at times we need to advocate for them to get that help until...they've reached a baseline again where they're able to understand, even if they're never able to understand. But to put them in a position where they're safe for that period of time..."*

A Leave Certificate or community treatment order under the Mental Health Act were orders issued by a psychiatrist and agreed upon by an individual and/or his or her substitute decision maker, which allowed the individual to receive care and treatment in his or her own community. A Leave Certificate was deemed less restrictive than being detained in a psychiatric

facility and was a tool that could be used in the ambulatory care departments where the nurses worked. A Leave Certificate was used for those people, who had repeated psychiatric admissions and who did not voluntarily engage in outpatient follow-up. The nurses also worked with people where Orders of Committeeship were applied under Mental Health Act legislation. The purpose of an Order of Committeeship was to protect the property and personal well-being of individuals, who were considered to be mentally incompetent. A public trustee was appointed in the position of proxy or custodian to ensure that a person's property or personal care was managed. A person could be deemed incompetent to manage his or her financial affairs but could remain autonomous with regards to decisions around other areas of his or her life. Two of the nurses talked about respecting an individual's choice and opinion in spite of the ways that Mental Health Act legislation applied to a person. Brenda tried to help the person feel comfortable by acknowledging the person's thoughts, feelings, or concerns. For example, if a person was required to take medication, Brenda supported the individual to have as much choice as possible about which medication the person used.

### **Resources for the Journey**

The nurses spoke about resources that were helpful and empowered them to advocate in the psychiatric nurse case manager role as well as the ways that they tried to provide resources for people involved in their practice to advocate in the course of their recovery journey. Experience, learning about systems, and role-modeling were all themes reflected in the nurses' narratives about actions that instilled individuals and themselves with additional confidence to advocate.

#### **Experience.**

All of the nurses in this study came to their current role as psychiatric nurse case managers with varied experience in other nursing roles in mental health services, as previously described. Most of the nurses alluded to advocacy being part of the role in nursing positions that they had held in the past, however they had to learn ways that advocacy was practiced and applied when they began in their current roles. None of the nurses explicitly mentioned learning about advocacy as part of their formal education or training as nurses, rather most of the nurses emphasized that learning about advocacy in the nursing context came with experience. Half of the nurses talked about ways that their experience empowered them to become more efficient advocates for the people in their practice.

*"...it's also kind of empowering for myself in that with each of these situations I feel, you know, a lot, uh, like a have a lot more skills. And I'm a lot more able to help other patients."*

They talked about the confidence that they derived from having experienced a similar situation in the past, and knowing the direction in which to successfully steer their future advocacy activities. Teresa believed that learning ways to advocate in her role was an ongoing endeavor. She explained that even though she had been in her position for a few years, she still was learning every day.

Individuals in the nurses' practice also were empowered to advocate based on their own experiences over time. Sara explained that people left her practice either by dropping out or through discharge. At a later time, these people might return to Sara's practice if they became unwell again. The work between the nurse and the individual was thought never to be entirely lost, according to Sara. People were thought to remember some of what they had learned and people were thought to be in a better position to navigate around the roadblocks associated with their journey to recovery based on their own experiences. The ways in which Sara used a

person's experiences to help he or she become his or her own advocate is discussed further in the section on therapeutic relationships.

### **Learning to navigate systems.**

For all the nurses, the ambulatory care or outpatient settings, in which they practised, were attached to a hospital. The outpatient environment was not considered to be the same as acute in-patient care or community mental health service settings. The nurses did not work within a silo, but rather had to have the knowledge and ability to navigate through the systems and people attached to all three settings. Additionally, the nurses talked about carrying out advocacy activities with family members; physicians; other professionals; pharmacists; or staff of hospital departments, community resources, social services, or volunteer placements. A couple of the nurses were newer to their roles and they explained that an overwhelming level of knowledge was required to know ways to navigate all of these systems and where to direct advocacy activities. Ready access to colleagues with experience helped save Brenda from making multiple time consuming phone calls to find out information.

*“And then sometimes there isn't any. Right. I'll look down the hall, everybody's door is shut and there's no doctors. And I'm like, OK, I will do this on my own. If it needs to be done, you know, sooner than later.”*

Robin explained,

*“...every time you enter into another doorway, you're entering another system which has different connections, different expectations...And sometimes I think if I have the level of knowledge and expertise, and I struggle to navigate through the system, how in the hell are we expecting people to navigate on their own?”*

Robin suggested that allocating specific time to get to know individuals working within the various resources could be helpful to acquire the needed knowledge to navigate other systems. Michelle echoed this sentiment and gave the example of spending time at various

community resources, or self-help agencies such as the Schizophrenia or Mood Disorder Societies.

Empowering oneself to advocate in the psychiatric nurse case manager role also meant having an understanding and learning about the methods of travel or the ways in which to enact advocacy activities. The vehicles through which nurses commonly advocated on another's behalf included: speaking in person, filling out forms, writing letters, making phone calls, and sending email. Knowing information such as which form was the most appropriate for the situation, or whom to email was an important part of the knowledge acquisition required to prepare oneself to advocate in this role. Robin described using the phone and email as the primary means in which to communicate and find the answers she required.

*"The phone is my friend. I don't know something. Er, the email is my friend. I type in, where do I go for this? What about this? Have you heard of this?"*

Brenda's day was often consumed with phone calls.

*"Just picking up the phone and connecting with someone to me that's advocating for patients. Like you know, like just me reaching out to community resources on their behalf is advocating for them."*

Easy access to the computer in her office allowed Kelly to look resources up on the internet together with individuals as a means of giving people quick information.

Most of the nurses experienced advocacy as teaching and providing individuals and their families with information about the mental health system and other community supports in much the same way that they learned themselves. Sara stressed that advocacy entailed giving individuals information, including material on system navigation to better prepare people to access knowledge that they needed on their own behalves. She tried to prepare people for some of the potential barriers, which are typically experienced when accessing the health care or social welfare systems.

**Role modeling.**

Brenda traced her advocacy knowledge acquisition back to her early days as a new nurse.

*“...in my experience through my career, it’s watching other people advocate is where you learn the tools of the trade, right.”*

One of the nurses provided instructional teaching to under-graduate nursing students in mental health. She talked to the students about role-modeling and learning ways to advocate from experienced nurses. Sara emphasized that role-modeling was a helpful part of the process for the new psychiatric nurse case manager, who is learning about advocacy in this role. The nurses worked within their own office spaces where the benefit was that they could meet privately with individuals or their families to conduct their work. Unfortunately, watching other nurses in action or opportunities for role-modeling was not always possible when others with more experience were sometimes confined to their offices with the door closed.

Role-modeling also was an important way that the nurses described helping to empower the individuals in their practice to exercise advocacy on their own behalves. The ability to watch the nurses at appointments make important phone calls or observe them during interactions with others was thought to be beneficial. Role-modeling was one way that could allow people to learn what to say and ways that they could choose to conduct themselves. The next time the person might feel more confident to make the phone call or know what to say to act on his or her own behalf. Brenda shared an example of ways that she had role-modeled for one gentleman, who needed to find a dentist and was not sure how to go about finding one or setting up an appointment with this professional.

**Travelling Solo and With Others**

The nurses worked autonomously and at times advocacy could be a lonely experience. Brenda spoke about some of her advocacy experiences being unknown to the individuals in her

practice, or other professionals. Despite, some of the nurse's advocacy experiences being unknown to others, the nurse was present, or together with individuals and their loved ones on their journeys. The individual's journey towards the destination was often facilitated by other people, such as family members or other professionals joining alongside. Kelly said, that "...it all goes back relationships", which was a theme expressed by all the nurses. Cornerstone to their ability to successfully advocate was the notion that the nurses had to nurture and continually maintain or establish connections with other people. The nurses spoke about ways that their relationships with colleagues and the therapeutic relationship with people allowed them to feel empowered as advocates. The nurses also shared the ways that the therapeutic relationship empowered the individuals in their practice to feel more confident to advocate for themselves on the journey towards their recovery destination.

### **Relationships with colleagues.**

Building rapport and collaborating with immediate colleagues was particularly important to the nurses. Immediate colleagues included other psychiatric nurse case managers, psychiatrists, occupational therapists, and social workers with whom they had worked in regular consultation. Kelly stated,

*"...if you've got a good team working together and you've got a supportive family. You've got...supports in the community for the patient....You know if you're able to work with that group...and so I think teamwork is what makes things work well."*

One of the nurses talked specifically about the importance of feeling valued and having her clinical judgment respected by colleagues. Having the trust and support of co-workers allowed the nurses to problem-solve, consider new ideas, and access other resources, which empowered them to act in advocate capacity. Kelly deemed a good working relationship, with immediate treating psychiatrists on the team, as essential. Teamwork was particularly important

during times of crisis. During critical moments the nurses may have had to rely on colleagues for coverage of their practice particularly if leaving the confines of the department was necessary. Robin shared a sentiment echoed by most of the nurses,

*“Truthfully I think colleagues’ knowledge. Uh, being able to say, uh, to someone you work with, I have this person. I have this situation. I don’t know what to do. I don’t know where to send them or to direct them. Any thoughts? Any ideas? There’s usually a wealth of information and resources. I find that very helpful.”*

The nurses revealed the tough issues they had to face in the course of citing the examples from their work. A couple of them commented on the ways that the support and collaboration with colleagues helped them to advocate through challenging situations.

The nurses were empowered to advocate if they had positive relationships with immediate supervisors, or from managers or administrators. Three of the nurses talked about needing to feel trusted by those persons, who were in positions of formal leadership. One nurse talked about ways that she felt somewhat misunderstood by administration and that a lack of awareness of the importance of advocacy within the role existed. Two nurses spoke about the necessity of managers to understand the nurses’ need for flexibility in their role.

*“And having support from, you know, administration to allow us to be flexible in what we do because I think flexibility is a real key thing in, in advocating and facilitating, um, for our patients. Um. You know we have our caseloads and we have our structured kind of day. But things come up. So...if I’m able to say to my boss,...I’ve got this thing going on in the community, I’m going to have to leave for an hour or two.”*

### **The therapeutic relationship.**

The therapeutic relationship was part of the process that helped both nurses and individuals in their practices with the resources needed to take on the role of advocate, and was a theme repeated throughout all the interviews. One nurse explained the ways that she familiarized people to the therapeutic relationship. Characteristics of the therapeutic relationship also were shared by the nurses. Intertwined, with the over-arching theme of the therapeutic



relationship, were the sub-themes of knowing oneself, helping others to know themselves, and helping others to know the person seeking care.

Sara explained the importance of orienting people in the beginning, about their expectations from the therapeutic relationship. Individuals often had no context or experience with mental health services when they were new to the nurse's practice. Sara taught individuals about what to expect in terms of her availability, and she was up front about their relationship being time limited. Sara reviewed with people that she would see them more often in the beginning and eventually their contact with each other would taper as they felt better. A challenge for Sara was to ensure that she did not create a sense of dependency on the therapeutic relationship. Sara shared an example from her work.

*"...And I said to her one day, so who else do you talk about this kind of stuff to, hey, the struggles? You know figuring out relationships. And she said, I don't need anybody else, I have you. And so clearly that's a problem because...we want people to have way more than us."*

In order to help people move along in their recovery journey, Sara encouraged individuals to connect and avail themselves of their family, friends, and other systems in the community. According to Sara, encouraging people to expand their social sphere was important because the focus for the nurse was on active treatment and not on care-taking. Currently, more attention was paid by the nurses to discharge people from their practices than had been the case in the past. Sara's experience was that some individuals were followed by a psychiatric nurse case manager for 25 to 30 years. Sara talked about the process being different in order to teach and talk to people, who have been followed for a long time, about active treatment and discharge. The therapeutic relationship was about trust and reassuring people that the nurse was going to stay consistent in her role and Sara deemed it challenging to change therapy rules with people, who had been engaged in follow-up for many years.

*“...And so how do you start to talk to people about that? About how things are going to change. And what it’s going to mean not to come.”*

All the nurses talked about the characteristics associated with the therapeutic relationship. The importance of trust was interspersed throughout many of the examples that the nurses provided. Trustworthiness meant following through on your word, according to Brenda. She felt being trustworthy was particularly important as she was newer to the role and was in the process of establishing relationships with people. The nurses also experienced the therapeutic relationship as one where encouraging and reassuring words were provided to people. Sara spoke about validation and normalization as techniques that she used within the therapeutic process. All of the nurses talked about being supportive and available for people either by phone or in-person. Being present was important. All of the nurses gave examples of the ways that simply being physically present and actively listening created a sense of safety and comfort for people to be able to speak for themselves and express their goals. The characteristics of the therapeutic relationship were highlighted in the following example.

Kelly described the therapeutic relationship that she had with Cathy\*. Cathy had been involved in a volatile domestic situation. She ended up staying with people randomly and felt somewhat lost after her boyfriend ended their relationship. Cathy’s mental health deteriorated and she was struggling with untreated symptoms of schizophrenia after she stopped using her medication. Cathy’s crisis was compounded by use of street drugs and a lack of any income. Her problems worsened and she came to the crisis centre presenting with auditory hallucinations and evidence of not having eaten in some time. The clinical staff at the crisis centre had difficulty communicating with Cathy. Kelly was contacted and assisted the crisis centre staff to conduct a mental health assessment in order to facilitate hospitalization.

Kelly knew that the therapeutic relationship she had with Cathy was helpful. She thought her presence would help soothe Cathy and provide reassurance to Cathy that she was safe.

*“It’s about her...trusting me....I wasn’t telling her what to say. I was just there and having been there as a presence, um, allowed her to speak about what was actually happening in her head and in her life. Um. So it was more of a supportive kind of role that I played there. Um. And encouraging her and, and reassuring her that things would be OK...”*

Kelly maintained contact with Cathy and the inpatient staff throughout her hospitalization as a means of nurturing their therapeutic relationship. Kelly talked about the importance of creating a sense of emotional and physical safety with Cathy. Kelly believed that sense of safety allowed Cathy to begin the process of identifying her wants and needs in a more specific way. Until that point, Cathy was only able to articulate that she wanted help. Kelly explained that her role was to inform Cathy of various options and provide her with some direction on her needs after discharge from hospital. Kelly helped guide and support Cathy to make those choices in collaboration with the inpatient staff. Kelly was certain that their therapeutic relationship was part of the catalyst that helped Cathy to use her own voice. The ability to listen and hear Cathy’s voice also allowed Kelly to make appropriate referrals to various services in the community on Cathy’s behalf.

### ***Knowing oneself.***

Part of acquiring the resources to act as an advocate in the psychiatric nurse case manager role was to regularly engage in a process of introspection. All of the nurses stated that they valued a person’s right to self-determination and they strived towards advocating for the individual’s point of view, rather than their own. They all stressed the importance of not advocating to bring attention to themselves but rather to help people access their needs or wants. Brenda explained that the nurse must have a clear sense of professional boundaries and consider

the purpose of advocating. Two nurses implied that advocating for self-promotion or self-satisfaction was unethical. Brenda stated,

*“...So I’m not doing it because I want to feel good about myself...I’m doing it for the patient.”*

Robin recommended that understanding one’s own values and beliefs was helpful within the process of coming to know oneself. Knowing oneself also meant addressing issues of countertransference. Countertransference was defined by Austin and Boyd (2010) as “the nurse’s reactions to a patient that are based on the nurse’s unconscious needs, conflicts, problems, and views of the world. It can significantly interfere with the nurse-patient relationship” (p. 994). Brenda acknowledged a time when she had neglected her own feelings of negative countertransference that she had towards one individual. She explained the ways that her personal feelings played a role in making the decision not to advocate. Neil\* was living in a rural community and he would call Brenda on a daily basis to make inquiries about medication changes. Suddenly, he wanted to move to the city without any clear rationale that Brenda could understand. Brenda did not take any immediate action to support this transition, as she did not have opportunity to talk with Neil regarding the move to discuss his rationale for wanting to make the move. Extenuating circumstances existed and Neil remained connected to Brenda’s practice. She believed that facilitating Neil’s move would have been a complicated process involving large amounts of organizing and transferring of resources. A few weeks later, Brenda learned that Neil had physically attacked a family member in the context of illness exacerbation and Neil was subsequently hospitalized. She questioned whether her decision not to advocate was about avoiding the concerted effort to advocate for scarce resources in the city only to see him go back home in short period of time. She disclosed feeling a bit guilty about the way that events unravelled and wondered if she should have been more proactive. Upon reflection,

Brenda reasoned that the above unfortunate events could have happened anywhere. Brenda felt this example from her practice was a reminder to pay attention to feelings of countertransference and to carefully consider the ways that one responds to those feelings.

The nurses sometimes needed the help of their colleagues to help them recognize and manage issues of countertransference. Brenda also provided an example of helping a colleague to recognize negative feelings that they were having towards a person who was acting in a negative manner. The colleague did not want to facilitate setting up an appointment with the individual, based on this behavior. Brenda prompted the colleague to question whether or not she was saying no to be helpful or therapeutic to the individual. Kelly also talked about the importance of recognizing when to seek out second opinions from peers as part of the process of knowing oneself. For example, a nurse could talk to a colleague if one was feeling baffled by a situation or relationship with someone involved in his or her practice. Kelly explained,

*“Like maybe I’m not seeing something so if I’m in a struggle with somebody that I think needs some help and I’m just not quite sure the clear direction, I’ll often talk with my colleagues and say, OK, this is, I’m in a bit of a bind here. Can you help? Can you help me see it? Maybe I’m missing something. Maybe there’s something in the bigger picture. So, you know, having peer support.”*

The nurses needed to understand and know themselves in order to have the adequate resources to act in advocate roles. The nurses also described helping others to know themselves as a process of helping others acquire the resources needed for their own advocate roles.

### ***Helping others know themselves.***

Advocacy was experienced by the nurses as engaging individuals in therapeutic practices and processes. The nurses practised various types of therapies in order to help people understand themselves and learn about the ways that their illnesses impacted their lives. The nurses referred to either supportive, cognitive behavior or short-term psychotherapies as some of the therapy

modalities that they used. Teresa talked about her department offering more cognitive-behavior therapy groups which helped her offer people more ways to manage their illnesses.

Sara explained the process of therapy for individuals in her practice. In Sara's opinion, it was important to understand that people often become ill at key developmental periods in young adulthood and so may not have had opportunity to learn or develop the skills necessary to function independently or be engaged in long-term serious relationships.

*"So I sometimes see young people and, or maybe not as young, but I see people who also have some strikes...before they got sick."*

Sara stressed her belief that the most important part of advocacy is getting to know a person's history and the ways that a person functioned before he or she became ill. Kelly also stressed the importance of knowledge and really understanding the individuals involved in her practice. Sara believed that knowing a person was a critical part of the process for helping a person move on and discover his or her goals or understanding the meaning of recovery for the individual. Sara explained that helping a 19 or 20 year old person achieve a high school equivalency could be a very different process from helping someone, who is married with children, achieve the same goal. Sara pointed out the importance of checking with people to determine if they want to go back to a point where they previously functioned or if they wanted a different goal. Knowing the people involved in the nurses' practice allowed the nurses to know the possible programs, professionals, or next steps to suggest to the person. Sara gave the example of referring someone to an occupational therapist for a career interest test. Sara asked people a variation of the following questions,

*"Things like did they have a work history? Were they married or are they still married? Do they have families? Uh. What do they have in terms of friends and stuff? And so how do we help them get well enough and/or help maintain that, those systems. And maybe that's about writing letters to work or those kinds of things. So that we can get people back, um, so they function at the level they functioned before."*

Sara worked with Sam\* who struggled with resiliency and bouncing back from setbacks, particularly related to issues at work. He found hearing the ways that Sara understood his recovery and developmental history, to be helpful. Sam had made significant progress over a period of five years despite having worked at two jobs, where he had been unsuccessful. Sara explained that he had gone from being a very isolated and unwell young man to effectively functioning in most parts of his life. She reminded Sam of all that he had accomplished despite still struggling to overcome the hurdle of returning back to work. Sara explained that she moved on to helping Sam obtain the skills to manage in the workplace and handle difficult feedback from his bosses. Sara stressed the importance of being realistic around setting goals in addition to adding structure to one's life.

Sara explained that in some ways helping people acquire their basic needs was the easy part of initiating a therapeutic relationship. Helping people heal and discover their recovery goals was deemed more challenging. Sara stated that she generally began by teaching individuals and their family members basic information about their illnesses being experienced. She stressed the importance of self-care and getting back to basics by helping people re-establish structure back into their lives.

*“...you really want people to know what they can do, what they can put into their life in order for them to weather the storms. Hey. And so there are some parts of this that are probably the same for everybody.”*

Helping people “weather the storms” involved talking to people about the importance of behavioural activation and goal-setting. Behavioral activation and goal-setting involved encouraging individuals to work on detailed smaller goals, such as regular meals or sleep hygiene to help people move towards their bigger, longer term goals. Encouraging someone to work on smaller goals could be as simple as suggesting that a person sit in the backyard for ten

minutes or unload the dishwasher. Sara worked with people to develop goals around reading or writing when illness impaired their ability to pay attention or concentrate. Sara also used cognitive behavioral therapy strategies such as thought records to help people understand their beliefs.

The process of helping people put structure back into their lives could take many weeks. Sara thought that promoting structure was a critically important step as people gained the ability or tools to engage in other programs or return to work. She explained that routine and stability were important,

*“...because you can’t do very much if you’re sleeping til 3 and 4 in the afternoon.”*

Kelly shared this belief and explained that one of the biggest barriers for the population with whom she worked centred on helping people structure their time. She recommended step-by-step processes to help people to move on and undertake more demanding goals.

Sara advocated for people, who were employed, to be off work for periods of up to three months in order to give individuals time to heal and put structure back into their lives. Sara’s experience was that individuals feel much more empowered and in control when they have achieved a sense of structure and stability. Additionally, they have a better idea of the areas of their lives that they want to work on or not change.

Sara talked about the importance of hope. Her experience was that people often came to her practice very ill and struggle to believe that life possibly could get any better. She provided reassurance to people when she told them that she had experience with helping people achieve their goals. She taught people the rationale for her suggestions and the order that she used so as to help instill a sense of hope and confidence. Sara explained that when people began various programs or therapy groups they sometimes struggled to believe that the programs or groups



would be helpful. Sara explained that a significant amount of the work that she did was to instill hope and encourage people to remain engaged in those programs or groups. Sara also prepared people for the road ahead by explaining that she expected problems along the way and alerted people to the kind of problems they could face along their journey. She reassured people by explaining that she would strive to give them some tools to know the ways in which to manage different systems or relationships.

Individuals were described as achieving levels of wellness, where they were discharged from the nurse's practice, although they might return after a relapse of illness. Sometimes, people were not ready to manage their illnesses and they left treatment. Regardless, Sara believed that the work she did with people never was entirely lost if they left her practice and later returned. Sara's experience was that people often returned with the ability to build on previous learning. Sara explained that a nurse can use her history with people to help instill a sense of hope. Paying attention and reminding people how far they have come in their recoveries was key to the role, such as in the example of Sam.

*"...if you have somebody who's had some stability in their life, clearly you can use your history with them. And their history to teach them how they've been able to do that. OK. Because it's very empowering to say, well, you know, my goal for you is to get back there if that's what they want."*

Sara provided an example of one young man's words to her when she reminded him of what he had accomplished.

*"...you know, you keep giving me examples of ways that I've improved. He said, and I don't see any of them. [chuckle] And you do that over and over he said. I just really like that, he said, because I don't realize those are good things and yet look how much further I've come..."*

Sara said that getting excited for people and instilling hope was a rewarding part of her job. She described her role as being similar to that of a cheerleader in this regard. Teresa also talked about identifying a person's strengths for him or her.

*“...Seeing that people do have skills, that they do have strengths. And I think that, that’s what advocacy is about. Just looking for those. Looking for those, those little tidbits, those jewels, right? And building on that. So I think that’s what true advocacy is about...”*

Sara provided some note of caution about hope. Her experience was that hope was an essential part of the recovery process but hope only went a limited way in helping people recover. She explained that along with hope people need information and skills to feel empowered enough so that they can move towards independence in managing their own illnesses and advocating for themselves. Sara tied this idea to the importance of teaching people about themselves, managing illnesses, resources, and re-establishing a sense of structure and control over basic elements in their lives.

Sara shared that in her experience sometimes internal barriers or core issues could hinder a person’s ability to move along his or her recovery trajectory, which stopped him or her from meeting his or her goals. Sara occasionally engaged in a process of short-term psychotherapy to help people overcome the hurdles that impaired their ability to progress.

*“...there’s often a core problem with people or issue that you really need to address with people. And whether that’s loss, whether that’s change, whether that has to deal with stuckness in terms of their own families or what is it that they’re afraid of or what are the issues that they have to manage in order to move on in terms of work, um, other relationships.”*

Sara also helped people come to terms with the meaning behind their diagnoses as a process of assisting people to learn and understand themselves so that they could move along their recovery trajectories. Sara worked with Anna\* who had asked her husband for a divorce in the context of a manic episode and he had agreed. Over time, Anna was feeling healthier and asked her husband why he agreed and he explained that he could not cope with her illness.

*“And so she has really started to appropriately grieve and really struggle with that whole better-and-worse thing, but also more importantly has said to me, what does this manic episode mean? What is it going to mean in terms of my life, in terms of work? What is it going to mean in terms of future marriages and relationships. How do I tell people? How do I tell my next significant other about the fact that I got manic and I had to be hospitalized?”*

Robin also supported family members, who had neglected their own needs in favour of the person living with mental illness. Robin explained that advocacy could mean letting family members know that it was acceptable to be more engaged with their ill family member or to establish limits with their ill loved one in order to attend to their own health or needs. Robin and Brenda both shared their belief that advocating for the whole health of the family was advocating for the individual.

***Helping others to know the person.***

For the nurses, advocacy sometimes meant working with people to help them navigate various types of relationships. The nurses worked with some people, who were unable to express their own voices in order to let others know their wants or needs. Kelly explained that a person may not have the language skills or cognitive ability needed to explain his or her wants or needs, so the nurse acted on the person's behalf in order to help others to know the person.

Kelly provided two examples of the ways that she acted as the voice for two individuals in her practice. She explained that knowing the individuals well helped her to advocate for their interests. Kelly had the experience of preventing other professionals from overreacting and rushing to intervene prematurely for one gentleman. This gentleman was new to a group home and within four hours of arrival had wandered away, thereby alarming the staff, who had reported him as a missing person. Kelly was able to educate the staff about the individual and explain that this behaviour was common for this man and not to get overly worried or panicked about this behaviour too quickly. Kelly provided another reason for the value of the therapeutic relationship and getting to know the whole person. Other health care professionals often contacted Kelly seeking her opinion on an individual's mental status and situation. She worked with a woman, who was hospitalized for physical health reasons. The medical staff at the

hospital became concerned about the woman's mental status and contacted Kelly to get her assessment of the woman's baseline mental health presentation. Having an effective therapeutic relationship with this woman allowed Kelly to express this woman's voice, when she was not in the position to do so on her own.

The nurses could act as go-betweens to interpret or express the point of view of other professionals to the individual or family members. Teresa acted as a buffer or intermediary between individuals in order to ease communication and decrease tension. Teresa worked with Mark\*, who was in conflict with a family member. Mark's family member had made attempts to have him involuntarily committed to hospital, despite the fact that he was not ill at the time. The family member was viewed as having personal motivations to use Mark's diagnosis against him to portray him in a negative light for legal purposes. Teresa found herself speaking on Mark's behalf in order to protect his interests. The nurse did not act just as a buffer between individuals, family members, and significant others. Some of the nurses stated that individuals, other health care providers, or community supports did not always get along with one another. The nurse acted as a buffer between these relationships to help ease communication and tension by interpreting differing points of view to the other person.

In a similar light, Sara talked about ways that individuals, who were new to mental health services, could be overwhelmed by the types of questions that are asked of them by mental health professionals, particularly psychiatrists.

*"...And I think that if you take somebody, say a woman who's coming in for an assessment, and they're really sick, that part of the challenge sometimes is figuring out what they have. But people have no experience with us and what that looks like and the kinds of questions we ask and how we will work through the process of assessments and information to reach an answer."*

Sara commented on preparing people for some of the jargon and rationale for certain types of questions asked by professionals as an example of the ways that she has helped individuals navigate relationships with professionals.

*“I think part of our advocacy for people is to teach them about what working with a psychiatrist or another team would look like so that they can just manage or tolerate getting through the interview.”*

### **The Journeys and Time**

Time, in some form or another, was a repeating theme throughout all of the nurses' interviews and time was part of their experiences with advocacy. The researcher was impressed by the idea that time was precious to the nurses and their advocacy efforts. The nurses discussed working with two groups of people over the course of time. The nurses worked with individuals who were involved with their practices for many years as well, as those who were newer to the nurses' practices. Advocacy for the nurses was time consuming, occurred at different moments in time, involved deadlines, and the right timing. The nurses also needed to be able to prioritize and be flexible, as part of their advocacy experiences involving time.

The nurses' relationships with some people in their practice could span over many years or even decades. The road towards recovery was often long with many hurdles to be overcome, which often influenced the advocacy efforts of the nurse. The nurses also travelled with some people along their recovery trajectories for shorter periods of time and only for a portion of their journeys. Two nurses commented on the pressure to discharge individuals from their practices in order to meet the demands of other people, who were accessing the mental health system. The nurses received new referrals to their practices from a variety of sources, but they generally followed individuals after an acute exacerbation of illness and hospitalization. Time was associated with shorter hospital stays, meaning that the nurses were seeing people, who were still

very ill and at high risk of re-hospitalization. Sara explained that often people were discharged from nurses' practices when they had achieved a certain level of independent functioning and not necessarily once the individual had achieved all of his or her long term goals for recovery. Relationships with individuals in the nurses' practices were therefore time limited over the course of a couple of years in order to meet the demands of a pressured mental health system. Relationships with the nurses could be time limited because the individual required a different type of service delivery, such as the outreach associated with an assertive community treatment model. In an outreach service, health professionals were able to travel to a person's home to provide mental health care.

All of the nurses emphasized that completing advocacy activities required a great deal of time. Half of the nurses proposed that advocacy was something that they had undertaken on a daily basis. Kelly shared a sentiment echoed by all the nurses involved in the study,

*"And I think if you were to sit down and kind of look at the amount of time you'd be flabbergasted at the amount of time I do spend doing that."*

Advocacy could be time consuming and could occur at intermittent intervals over the course of many hours or days depending on the person and the issue. Filling out forms for disability, social assistance, transportation, or housing were deemed necessary, but time consuming activities. The nurses could complete the forms or time was taken to remind psychiatrist colleagues to complete the task at hand. Regardless, Robin declared,

*"I have in this role never filled out so much paperwork in my life".*

Deadlines were associated with submitting some of these forms and great seriousness was placed on ensuring this work was done in a timely fashion. A person could be in crisis if the nurse was not efficient with completion of the paperwork. Being savvy with the right timing or knowing when to advocate was associated with successfully achieving one's advocacy goals.

The nurses described needing to be aware of openings to various programs or times that other treatment services were accepting referrals. The person's emotional wellbeing, livelihood, place of residence, or more suitable treatment options, could be impacted if deadlines were missed. Michelle explained that she could not always wait for the individuals to complete the tasks themselves. At times, Michelle was in a position of enlisting others to get a task done in a more efficient manner to help avert a crisis that could be caused by missing a deadline.

The nurses needed to occasionally leave the confines of their ambulatory care departments and venture into the community to assess an individual's wellbeing or to attend a meeting on behalf of someone. Leaving the ambulatory care department was not always frequent, but was considered to be time consuming and may be necessary for helping individuals stay well. Medication outreach was not available to some individuals from other community sources and some of the nurses travelled to people's homes to administer long-acting depot medication. Travelling to people's homes required time in a nurse's schedule and Kelly talked about the need for administrative leaderships' support and understanding in these circumstances.

In general, the nurse's day was structured with therapy groups or individual appointments that were scheduled in advance with people, their loved ones, or other health care providers. Despite this structure, advocacy carried out on an urgent basis could occur unexpectedly in the course of the nurse's day, particularly. Advocacy conducted on an urgent basis was particularly relevant where issues of crisis or safety were concerned. Adding to the complexity of the situation, often crises did not occur in the ambulatory care department but rather somewhere in the community. The nurses stressed that being flexible and prioritizing one's time were both factors, which could facilitate a successful outcome in these circumstances.

Brenda worked with Carlos\* who had become acutely ill with psychosis and at risk to both himself and others. One day, Carlos' family arrived suddenly at Brenda's office. Carlos' family members were clearly afraid of Carlos as a result of previous episodes of physicality directed at them in the past when he had been unwell. In a matter of a few minutes, Brenda was forced to re-evaluate her structured day and the impact this situation would have on other tasks and individuals, whom she had planned to meet. Brenda and Carlos' family members struggled to get Carlos to come to the hospital of his own volition. Despite concerted efforts, the assistance of police officers was deemed necessary to help the process to proceed safely. Over the course of the day, a significant amount of time was required to communicate with law enforcement. Brenda shared,

*"...it took me all day to get him to come in. It took me two calls to the duty inspectors. Three calls to dispatch. And this was, started at 9 o'clock. And by the time I left at 4, I was still calling the police. It was so frustrating. But again, that to me is huge because I had to advocate for the family. Their safety was at risk. And then my patient."*

Being flexible and prioritizing one's time was a necessary component of advocacy in Brenda's opinion. Brenda felt that getting the desired end result could take hours, depending on the situation. Therefore knowing the means to get the quickest response to a question or request was important. Several nurses explained that collaborating with colleagues could expedite the need for immediate answers. Colleagues were deemed supportive in crisis situations, but they could be engaged in their own tasks and not readily available for consultation. Waiting on professional support from others could be a time consuming process, which was not helpful during times of crisis. Community crisis services were often used by the nurses in episodes of crisis. Kelly advised that the nurse should be able to clearly identify the issues during times of crisis. Having clear evidence to support your concerns and being specific on the details in a person's life was deemed helpful for expediting the process. Despite the loneliness and



frustration of navigating some crisis, Brenda derived satisfaction from knowing that her problem-solving efforts could result in productive outcomes.

### **Types of Journeys**

The nurses were clear that their advocacy activities centred on helping individuals work towards their ultimate recovery goals. The types of journeys, the nurses undertook were described as aligning with the goals of the individuals involved in their practices. Kelly explained that ultimately she advocated to help people to have better lives. Brenda and Teresa believed that people just wanted to be happy.

*“I think most people just want to be happy. They just want life to, you know, uh, to not be in crisis. To just have contentment really.”*

The nurses described individuals who were living with severe mental illness as wanting the same goals that most people want. Contentment and happiness included being engaged in meaningful activities like work, school, or recreation. Acceptance by others and engaging in meaningful relationships also were deemed important wants and needs of the people in the nurses’ practices. The nurses also described people wanting to be free of mental illness symptoms. According to some of the nurses, people could have difficulties knowing or explaining their goals and some people needed help figuring out their goals. Persons’ wants also were considered to be their needs and the nurses in this study often used the terms want and need interchangeably.

The types of journeys the nurses engaged in, or the direction in which the nurses focused their advocacy activities, was comprised of three types. The first type of journey involved helping others acquire their basic needs, which was a frequent journey for the nurses. All the participants prioritized the acquisition of basic needs first. The second type of journey involved directing advocacy activities towards issues of power, stigma, and discrimination. The last type

of journey involved the nurses directing their advocacy activities towards assisting newcomers to Canada.

**Basic needs first.**

In some form or another, all of the nurses repeatedly spoke about the basic necessities of life not being readily available to the individuals in their care. The nurses worked with people living in poverty, who were grappling to access varying degrees of safety, food, shelter, transportation, and adequate health care. These types of journeys were familiar to the nurses and they tried to prioritize basic needs first when engaged in advocacy activities with individuals.

Robin stated,

*“...It always comes down to, it’s always so simple yet so basic is, uh, people can’t, uh, really work on their mental health unless their basic needs are met. And lots of people who come through these doors are struggling to get their needs met. Some of the advocacy work you do in the beginning, you’re not doing therapy.”*

Safety was mentioned in different ways by the participants and was often the basic need prioritized by the nurses. Advocating for safety could mean striving to keep the individual or others from risk of harm particularly if the individual was unwell because of illness exacerbation. The nurses worked with people, who were often living in vulnerable situations, which meant keeping an on eye on the individuals’ safety in the community. The nurses worked with some people who lived in dangerous neighborhoods and in poor housing conditions. Occasionally, advocating for safety meant helping problem solve around finding a safer place to live or a dwelling free of vermin, such as bed bugs. Three of the nurses commented on a lack of adequate housing in the community for individuals in their care.

*“I mean people aren’t going to offer you things or give you, give your patient things if you’re not clear....You know, in our system right now, housing is a huge issue....You need to be very clear why you want this person living in this kind of housing situation rather than this kind of housing situation.”*

Kelly commented that knowing your resources and being clear about the person's needs was important.

*"...I mean if somebody's got some mobility issues, well you don't want them living on the third floor in an apartment block."*

Access to physical health care often was a journey that the nurses embarked on with individuals. Most of the nurses mentioned helping people access family physicians or dentists. Michelle and Brenda often had to give explanation to other health care providers as to the reasons that persons could not call themselves when they tried to set up appointments and make inquiries on behalf of individuals in their practices.

Medication costs often were covered for individuals on social assistance, however affordability issues were described as the reality for people, who were employed at lower income jobs. Government programs such as Pharma-care are designed to allow a person to pay a portion of the medication cost based on the person's previous years' income. However a person's Pharma-care deductible could be unaffordable for some individuals. Similarly, the dispensing fees charged by different pharmacies could be too costly for some people.

The nurses also spend time assisting individuals to find ways of affording medications. Brenda worked with Irene\* who was struggling with maintaining her interest in using medication to help manage her psychotic illness. Brenda was trying to promote Irene's interest in using medication by finding an option that had minimal side effects and was administered monthly as opposed to bi-weekly. The long-acting medication chosen by Irene was costly. Irene was not able to work and was deemed ineligible for social assistance because of her husband's income. The family struggled financially and could not afford the Pharma-care deductible fee or the pharmacy dispensing fees. Brenda described a lengthy process of time-consuming advocacy aimed at acquiring medication coverage for Irene. Brenda eventually was able to access a

compassion program through the pharmaceutical company, which was not widely known and aimed at covering medication costs for people living on a low-income. The pharmaceutical company also was able to pay for a portion of the pharmacy's dispensing fee, but the five dollar remaining portion of the fee remained a hardship. Brenda explained that she had gone through a process of negotiation with various pharmacists until she was able to find one who was willing to dispense the medication at a reduced rate. Brenda believed that Irene and her husband would not have been able to complete this process.

The need for basic necessities did not happen just at the beginning of therapeutic relationships between individuals and nurses. Sarah shared a story of the importance of being thoughtful about a person's basic needs and reflecting upon the factors that could be barriers along the trajectory of a person's recovery. She worked with one young woman, who suddenly stopped attending appointments and going for bloodwork.

*"...And I said to her, why aren't you doing this? Like what's getting in the way? She said [participant's name], I have no bus tickets...and I can't afford to pay for my pills this month. So that was the problem, hey. So I think the problem is often to be able to sort of take a step back with people and really look at where they're at."*

Sometimes resources were available to people, however other factors played roles in individuals' abilities to access the services that they needed. Accessing adequate resources, particularly housing, could be denied based upon a person's prior negative behavior. The nurse's reputation amongst colleagues and service providers in the community was an important component of advocacy and could influence the willingness of others to make resources available to a person. Teresa and Kelly explained the importance of establishing trust and good relationships with community partners, as resources were scarce. Presenting oneself as empathic and knowledgeable to the challenges facing a landlord, community health care provider, or other outside partners was deemed helpful for getting people's needs met. Teresa shared,

*“People trust you that you’re not going to send them somebody who’s going to, um, go sideways on them.”*

Kelly explained that considering one’s reputation and being thoughtful about referrals and references was important,

*“Because it then risks it for the next person that you maybe want to get into a place.”*

Teresa and Kelly tried to be pragmatic about ways that they presented individuals to others. They were transparent to other care providers about a person’s struggles but they also expressed their beliefs in an individual’s potential. They reassured others that they would work together with community and service provider partners to help individuals to be successful. This collegial approach could mean keeping the lines of communication open, being flexible, and being responsive in a timely fashion, when supports such as group home supervisors or others called asking for assistance.

Brenda echoed this sentiment and acknowledged that some of the people in her practice had become impaired in terms of functioning and ability to care for themselves over the years. Some individuals had become estranged from other formal and informal supports. Advocating for people to maintain adequate housing in these circumstances could be challenging and difficult for the nurses. Maintaining relationships with the landlords of rooming houses and group homes was deemed to be essential and could be a key factor in preventing homelessness for a person. Brenda explained that one landlord of a rooming house identified two men who were unable to manage their financial affairs. Brenda agreed that the situation was far from ideal and she advocated for the men to have their financial affairs formally overseen by the public trustee’s office. Brenda believed that she had successfully advocated for the two men and the landlord of the rooming house.

*“Because I think if she’s [landlord] happy, then my patients will be happy, right? And then they [patients], you know, will make her job less stressful. And take that pressure off. And then my patients will still have a home versus her giving up and closing it or something which could end in...an even worse result.”*

A barrier to accessing a person’s need could come from within the individual. The nurses worked with people living with self-esteem issues, who did not believe that they were deserving or worthy human beings. Advocacy in these situations meant advocating to individuals for and about themselves.

*“Part of the skills that I’ve been trying to help people with, uh, smart people who are coming through the doors but they’re not eating. One of them because they don’t prioritize themselves and don’t recognize their own hunger. And the other because he has no resources...”*

Teresa believed that one’s beliefs and assumptions could preclude a person from accessing a basic need. Jonah\* had been homeless for six months and did not apply for any apartments because he was afraid that the reference from his last landlord would be negative. Jonah was intimidated by the process of finding an apartment on his own and so avoided trying. Teresa contacted the landlord and was able to get a good housing reference for Jonah. Teresa was able to show Jonah the process of filling out a housing application and the way to present himself positively to a landlord. Jonah was able to successfully get his own place after the help from Teresa. She believed that Jonah would have remained homeless had she not advocated on his behalf.

### ***Working around the system.***

The nurses developed individual ways of working around the larger systemic issues that precluded people from acquiring their basic needs. Kelly described a sense of lacking control over larger societal or systemic issues like poverty, which affected her practice.

*“There are, I mean there’s always, there’s often barriers that, you know, you just can’t help with whether it be in terms of appropriate housing. But that’s a systems thing. And I don’t*

*think that that's something that we can fix. We can certainly work hard to get the best. But sometimes the best may not be the best."*

Two nurses spoke of occasionally bending minor rules in order to help people have their needs met. The examples the nurses gave were transportation related issues. One of the nurses acknowledged periodically providing too many taxi slips. She joked about not giving out taxi slips for "evil purposes" but rather for the greater good. Giving out an extra cab slip or bus ticket to attend an appointment or some other necessary service could help facilitate that person's interest in using medication or accessing another form of treatment. The nurse believed that bending a rule like giving an extra bus ticket was much less costly for the health care system and the individual who might be at risk of hospitalization. The same rationale applied to the way that one nurse talked about carefully worded letters to social assistance in order to access bus tickets for a person. She explained that bus tickets were allocated based upon the number of medical appointments that the person had per week. Sometimes, the nurse over-estimated the number of times a person was expected to attend appointments in order to facilitate that person's ability to have transportation to some other kind of service in the community that might be helpful for his or her recovery.

Michelle sometimes worked around the mental health system to help people access psychiatric consultation. Michelle kept people's files open for a period of time after they were discharged from her practice and their psychiatric care was transferred to a family physician. The process for accessing formal mental health services could be complicated and daunting. Michelle wanted to facilitate individuals in getting timely psychiatric consultation after discharge from her practice if needed. Michelle felt pressured to keep a steady flow of discharge of people in order to allow others to access the service she provided. Michelle and the psychiatrist offered to see people directly for consultation appointments if they had any follow-up questions. They

believed occasionally seeing people for consultation appointments prevented people from being re-referred through a lengthy centralized intake process. Michelle gave the example of a woman being seen by her family physician for psychiatric prescriptions. This woman had questions around medication usage during her new pregnancy. The family physician felt uncomfortable giving advice to this woman about using psychiatric medications during pregnancy. Michelle and the psychiatrist saw the woman for a quick one-time consultative appointment to provide advice about using medications. The woman did not have to come back to Michelle's practice for ongoing follow-up. Michelle felt she had successfully advocated for both the woman and the family physician by working around the system. The family physician and the woman were provided with expedient answers to their questions around psychiatric medication usage and pregnancy.

### **Power, stigma, and discrimination.**

The nurses in this study were not immune to the realities of human suffering and were at times privy to the negative attitudes and actions aimed at individuals in their care. They shared stories of advocacy related to the stigma and discrimination associated with major mental illness and of societal inequities. However only one of the nurses explicitly referred to the term "stigma". The nurses did not otherwise use the terminology or state that they advocated against stigma, discrimination, or social injustice. They named issues of power imbalance and provided examples of power imbalances experienced in their practices. Issues related to power, stigma, and discrimination mattered to the nurses and they provided multiple examples of these types of journeys.

Three nurses talked about issues related to power. Brenda appreciated and welcomed the idea that sometimes other professionals were more appropriate for the task or may have better



tools to get a desired result. Brenda also explained that having the “right letters behind your name” or professional designation could give one more credibility or power to advocate successfully in certain situations. Three nurses explained that occasionally individuals were able to speak on their own behalves, but the nurse was compelled to advocate because her or his professional status exuded more power to get a response.

Many individuals in Brenda’s practice derived their income from social assistance. Brenda reiterated that for most of these individuals money was very tight. Brenda explained that individuals on social assistance, who volunteered for select non-profit agencies, were eligible to receive an additional monetary incentive. Brenda worked with Gerald\* who periodically had difficulties with receiving his volunteer cheque on time. Gerald struggled and would periodically falter into crisis when he was not able to get a response from his social assistance worker about his cheque, after trying to make phone contact for a week. Gerald relied on these funds to help him purchase food. Brenda periodically acted as Gerald’s voice to ensure he received his cheque on time.

*“And then if I don’t get a response, then I go call the supervisor which my patient wouldn’t normally typically do. And, again, just maybe being in the position that I’m in, I might have more power than the patient does. And advocating for him and then usually I can get, you know, a response within a day. And get the money by the weekend. The crisis is, um, averted. And so for him, he might not get that same response.”*

Brenda explained that sometimes individuals are not aware of the process to navigate certain situations and providing needed information ensures that they can act on their own behalves. Brenda tried to encourage people to speak on their own behalves, however she recognized that people living with severe mental illness were not always taken seriously by others. Brenda believed that she had more power than Gerald to get an immediate response from the social assistance worker. She speculated that Gerald might not be taken seriously enough to

be able to speak to a supervisor. Brenda felt satisfied when she was able to get Gerald's need met, but at the same time the process was time-consuming and frustrating to advocate in this capacity. She stressed that in Gerald's situation, she believed that she should act in a conscious way and remember to follow-up with the social assistance worker on a monthly basis to avoid a crisis around the volunteer cheque. Brenda would state a variation of the following statement to the social assistance worker,

*"And then so, um, usually, you know, I'll say who I am, where I'm from and I'll say my patient's about to go into crisis, we need this result. And then they will call me right back."*

Brenda did not always receive an immediate response from the social assistance worker.

*"...OK, if I don't hear from her in the morning, I will call again in the afternoon. If I don't get a response in the afternoon, I will call first thing in the morning and start going up the chain of command."*

Brenda tried to problem solve with the social assistance worker and Gerald, but the process was not easy. Brenda faxed the form, which verified Gerald's volunteer hours directly to the social assistance worker, as a means of trying to navigate some of the barriers involved in this situation. Brenda explained that this step was an addition that she had to complete in order to help Gerald avoid a repeating crisis and ensure he met his basic needs.

Michelle also experienced advocacy related to the power that her professional status exuded. Diagnostic overshadowing can be "common in general health care settings, meaning the misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to underdiagnosis and mistreatment of the physical conditions" (Thornicroft, Rose, & Kassam, 2007, p. 113). Michelle worked with Deidra\* who was known to the staff of one ER as she often frequented their department. Michelle believed that Deidra had been somewhat stereotyped by health care professionals and her physical concerns were minimized as a component of psychotic illness. Periodically, Deidra would be turned away by medical professionals in some emergency

rooms without receiving adequate medical investigation for her physical concerns. Michelle described frustration with needing to advocate for appropriate physical health care on Deidra's behalf and explain to other health care providers that Deidra's complaints warranted appropriate medical investigation. Michelle was aware that she was able to get Deidra adequate medical care because of the power associated with her own professional status. Michelle explained,

*"...she really physically needed to be looked at...So I was frustrated, but once I got there, and I had my badge on like it went smoothly. Right?"*

Teresa successfully directed advocacy activities aimed at another health care provider in the community, who was exhibiting stigmatizing attitudes. Teresa worked with Jane\* who was often disengaged from psychiatric follow-up and had repeated hospitalizations over the years. Jane required considerable support from community outreach, which was not typically a mode of treatment offered in an ambulatory care setting. In order to better suit Jane's needs, Jane had been referred and accepted for psychiatric follow-up with an assertive community treatment team, who provided enriched outreach services. Jane's name was placed on a waitlist before her care could be formally transferred to this service. Teresa tried to emulate outreach services as best she could with limited resources, while Jane waited for outreach services. Teresa put forth considerable effort to engage Jane in a therapeutic relationship by driving to her home, arranging for taxi slips and meal vouchers, as well as making trips to the charitable clothing depot at the hospital.

*"...I worked very hard to connect with this lady....she's been like not great. But she's a lot better. Her place is a lot more organized. Um. She's, uh, not using as much street drugs...She's been able to maintain her living situation for the past year..."*

Teresa understood that she was not able to engage Jane on her own and she believed that using medication on a consistent basis played a large role in improving Jane's circumstances.

Teresa liaised with another community treatment provider, who was able to provide daily

medication prompting. Teresa felt dismayed when this provider suddenly suggested that this service be stopped. Teresa strongly believed that Jane would suffer needlessly, as she had in the past, without medication support.

*“...I’ve been persistent. I have been persistent that we have to wait until [assertive community treatment] picks her up. Please just keep that [medication support] in place. We need to have eyes on her, you know, on a regular basis. Otherwise things are going to go sideways...”*

Teresa reasoned that had she not acted on Jane’s behalf and insisted that this service remain in place, Jane’s quality of life likely would have deteriorated back to a pattern of repeated hospitalizations and homelessness. Teresa was of the opinion that terminating the medication support was a hasty and premature suggestion. She implied that the health care provider showed a lack of effort to understand Jane and the challenges facing individuals living with severe and persistent mental illness.

*“Um. It’s a little frustrating that I feel like I’m advocating with a [health care provider]... that’s in the field just administering psychiatric meds that may not have an understanding of her....I don’t think she could ask this client, do you have schizophrenia or do these medications help you. And I don’t think that...she [health care provider] recognizes that’s what baseline is, that’s what insight is.”*

Michelle had similar frustrating experiences of communicating with other health care providers, who did not understand mental health related issues and subsequently rushed people through their services. Teresa described a sense of satisfaction and pride at having advocated on Jane’s behalf despite feeling frustrated with the health care provider’s perceived lack of understanding. Teresa viewed advocacy for Jane as a worthwhile process, which enhanced the therapeutic relationship and ultimately helped to improve Jane’s quality of life.

*“And I think that solely is based on the fact that she’s being treated. So to me that’s a success. And we’ve kept her out of the hospital and she hasn’t lost her place. So that, that is the kind of stuff that makes me. Like just warms my heart. Makes me feel good. Yeah. Because when you work so hard. And to me, I don’t know, that stuff’s fun. I really like the engaging because*

*this, this client was not interested in engaging us at all. And, you know, it is fun because the client's glad to see me....We have a relationship."*

Michelle talked about her experiences with advocacy and social inclusion for people living with severe mental illness. She encouraged people to connect with leisure activities in the community or self-help agencies such as the Mood Disorders Association, as a means of helping people develop a sense of social connection to others. She understood that building social connections to others was not a preference for some people and she respected this choice. Michelle explained that sometimes people were unwell and not ready to forge other relationships. Occasionally people were uncomfortable socializing because of issues related to the stigma associated with mental illness. Michelle helped people work through that stigma by encouraging connections with other team members, such as occupational therapists or social workers. Michelle occasionally accompanied individuals to community activities initially to help decrease some of their anxiety related to social inclusion.

Michelle shared another example of advocacy in relation to stigma and social inclusion. Stuart\* had sent damaging emails to his employer in the context of a manic episode despite advice from Michelle and his psychiatrist that this action could have negative consequences for his career. Stuart began to realize the significance of his behaviour when he was feeling healthier and Michelle was in the process of helping him work through this situation. Michelle was prepared to advocate on Stuart's behalf to help him improve the relationship with his employer. She recognized that the decision to act on Stuart's behalf was not entirely hers to make. She believed that Stuart was a competent adult and respected his ability to know the best approach to manage the situation with his employer. She explained that she would provide Stuart with suggestions so he could make an informed decision about the way to proceed with

explaining his behavior to his employer. Michelle felt ultimately that Stuart should decide if he wanted her to advocate on his behalf.

*“So, I mean, whatever he kind of suggests to us to do to help him we’ll do. But also if he says, no, I want to deal with it myself, we would just let, we would give him that space...”*

Michelle speculated that advocacy in this situation, meant potentially sending a letter to Stuart’s boss explaining that he had been medically unwell. She explained her thoughtful approach and was aware that sending a letter could result in either positive or negative consequences for Stuart.

*“...I guess it goes kind of patient to patient....I always say, be limited on how much you share due to the stigma of it...I mean absolutely, the patient says no, I’m fine. I share it. OK. I mean lots of people do share their stories and life goes on and they do well...but I always say to be cautious and make sure you do it with people you trust and um, I would never say absolutely not. Don’t. I don’t think there’d be a situation. Sometimes the less people know the better...”*

Michelle believed that nurses could play an important role in promoting inclusion in the workplace for individuals living with mental illness by speaking out as a professionals and promoting this issue. She recognized advantages to disclosing a person’s illness to an employer, however she was wary when people revealed too much information. Her experience was that individuals were generally stigmatized in the workplace when a person’s mental illness was shared. Michelle thought that employers, who were better informed about mental health related issues might be more flexible and understanding when individuals living with mental illness were struggling.

*“...it [might be] better for the employer to know so that they can, if they need a day off or a couple of hours for a break to kind of regroup and balance their symptoms it would be helpful...”*

Robin believed that some of the structures and policies associated with a public institution disempowered and restricted individuals living with severe mental illness. She

explained the intimidating and overwhelming exercise for someone distracted by auditory hallucinations to either go in person or make a phone call to a large government institution.

*“...you’re living with voices uh, and you have to pick up the phone, um, and get into a phone system where it’s, press 2 if you want to speak to whoever, press 3 and then wait for the next cycle and the next cycle and the next cycle.”*

Robin went on to explain that difficulties could be compounded if an individual was not articulate or able to use the right words to get a point across. Robin’s experience was that individuals living with severe mental illness could be diverted, cut off, or instructed to go to the back of a line when faced with navigating the bureaucratic channels associated with large institutions. Speaking English as a second language could add to this hardship. At times, Robin was prompted to advocate because she recognized that the person was exhausted and “tired of knocking on the same doors” and not getting a desired response. Robin felt this outcome was particularly unjust for people, who might not have the energy or emotional wherewithal to tolerate the nuances associated with complex government bureaucracies.

*“...And again if you’re having a hard time or you’re responding to internal stimuli and you don’t want to be around people, and then we say to you, oh just go stand in the [social welfare] office and see if you can get an appointment. That’s quite anxiety provoking.”*

Robin expressed her strong feelings about the unfairness that people living with severe mental illness sometimes faced when trying to access services unsuccessfully,

*“Well to put it bluntly, that irritates the shit out of me.”*

Robin assisted individuals with acquiring or maintaining their livelihood by completing paperwork for social assistance, long-term disability, or insurance companies. Completing paperwork to help a person maintain their livelihood could be a time consuming process but was also a necessity that needed to get done in order to help people meet their basic needs.

*“So sometimes advocacy is, uh, is having people come in for appointments and then you sit together and you make the phone calls and you support the person to make their own, uh,*

*efforts. And you stand by to offer support, often the emotional component, so they can do their own stuff. But they need that bit of oomph to do it.”*

**Assisting newcomers.**

The nurses travelled on journeys with individuals and families who were new to Canada. Brenda highlighted ways that the practices associated with enacting mental health act laws could negatively impact newcomers to Canada and those who speak English as a second language. Brenda explained that friends or family could have difficulty in getting help for a loved one, who was refusing to receive mental health services. She thought that getting appropriate help could be a difficult process for family members regardless of their experience with the formal mental health system. Brenda stated,

*“...it’s a very complicated process even for those who know what to do...”*

For individuals unfamiliar with Canadian law or official languages, difficulties in accessing appropriate help for an ill loved one was increased. In Manitoba, a family member has the option to go before a Justice of the Peace or Magistrate and complete, under oath, an application for an Order for Involuntary Medical Examination, when a family member believes that a loved one requires a psychiatric admission to hospital. If an order is granted, the family member is instructed to go to a separate location and take the form to a Duty Inspector in the Public Safety Building. At this point, assigned police officers have the authority (for a period of seven days) to bring the individual to an ER for an involuntary medical exam.

Brenda expressed empathic feelings for families in these situations. She also revealed her frustration with the process. Brenda made the following statement with heightened inflection in her voice,

*“And I’m just like, but you don’t understand, English isn’t their first language...How do I explain to go to the Law Courts and talk to a Magistrate when they don’t even know what I’m even taking about?”*



Going to the Magistrate and completing an official legal document for an involuntary assessment could be a traumatic experience for anyone, but particularly for people, who were non-English speakers and families in crisis, who were frightened for their loved one. Brenda tried to advocate and circumnavigate these situations by exploring alternative means to keep a person safe. At times, the only option to keep a person safe from him or herself or others was to direct family members through the difficult process of completing an order for examination through the Magistrate.

### **Collective Journeys**

All of the nurses primarily described their advocacy experiences as journeys that they undertook primarily on a micro or individual level. One of the nurses commented on the idea of a collective journey that one undertakes to promote a larger-scale cause or macro-level advocacy. Robin understood that this type of advocacy existed and was important, however she did not believe that advocacy on this level ordinarily was part of the psychiatric nurse case manager's practice.

*"...You can be a person on the microphone shouting for, you know, better pay, equal rights. Whatever that is. You can be a leader in that way...that's sort of one way of, of being an advocate. I think often in this role, advocacy is about small things. But maybe a thousand small things that you do that have meaning for a thousand individuals. That might be a cup of coffee that you bought. That's advocacy."*

Occasionally, Robin had acted together with colleagues to support a cause. She recalled expressing concerns as a group when an allied professional colleague's time in the department was at risk of being decreased. Robin explained that a reduction in this service would have had negative impact on the overall quality of care provided to individuals accessing the services of the department. Robin was not aware of the impact of her groups' advocacy efforts, however Robin felt good about having taken a position, stating it clearly, and making it known.

Regardless of the outcome, Robin thought that the effort, which the group undertook to advocate for the allied professional's position, was worthwhile. She stated,

*"...you gotta speak up. You can't complain in silence. You actually have to take action or your complaints have no meaning."*

The rich descriptions of the advocacy experiences of the psychiatric nurse case managers in this study provided the basis for the development of themes. Chapter Five, the discussion section, will be used to discuss the findings of this study and the implications for nursing practice, education, and policy development.

## **Chapter 5 - Discussion**

The main purpose of this study was to understand and appreciate the lived experience of advocacy from the perspectives of psychiatric nurse case managers working with individuals living with severe and persistent mental illness. Hermeneutic phenomenology was the research methodology that allowed for the discovery of the deeper meanings associated with the nurses' advocacy experiences within the context of ambulatory care settings, in a large city on the Canadian Prairies. Advocacy was deemed a primary role of the psychiatric nurse case managers, which was a finding consistent with previous studies on case managers' perceptions of advocacy (Hellwig et al., 2003; Tahan, 2005; Yamashita et al., 2005). Advocacy was experienced as a complex, and sometimes ambiguous undertaking for the nurses, as they navigated a complicated maze of mental health and other human services. Additionally, advocacy held several different meanings for the nurses, which was consistent with the different meanings associated with advocacy reflected in the literature (Breeding & Turner, 2002; Bu & Jezewski, 2007; Chafey et al., 1998; Curtin 1979; Gadow, 1980; Hanks, 2008; Jezewski, 1993; Kohnke, 1982; Mallik, 1997b; Snowball, 1996; Toda et al., 2014; Vaartio et al., 2006). This study and earlier studies about advocacy share the perspective that nurses mainly focus their advocacy activities at the individual and family level (Hanks, 2013; Spenceley et al., 2006).

### **The Meaning of Advocacy**

Advocacy was understood through the use of a metaphorical journey, which was helpful for discovering the meaning of advocacy, from the perspectives of the psychiatric nurse case managers. The nurses' journeys involved empowering themselves, in advocate roles, as they travelled along their own unique careers paths. The nurses supported empowerment of others, and joined individuals with their family members on these individuals' unique journeys, at

different points in time, in order to assist others towards their recovery goals. Advocacy was a dynamic process that had three different meanings, as the nurses travelled with others towards their recovery destinations. Firstly, the nurses spoke on behalf of others, as one of the ways in which the nurses characterized advocacy. Secondly, the nurse acted as a coach, or guide supporting autonomy, by assisting in the empowerment of individuals and family members to engage in self-advocacy. Lastly, advocacy for the nurses meant upholding social justice.

### **Speaking on behalf of others.**

Speaking on behalf of others involved the nurse using his or her voice to represent the values, beliefs, wishes, and desires of the individuals and families within the nurse's practice. The nurses recognized that some people were unable to express themselves, or could not speak on their own behalves. The nurses acknowledged that some people might not have the capacity to defend themselves, raise their own concerns, or ask for what they need, or want. The nurses also recognized that a person might be independent in one area of life, but unable to speak on behalf of his or her self in another area of life. Speaking on behalf of others usually occurred more often in the beginning of a relationship.

### **Supporting autonomy.**

Supporting autonomy involved respecting a person's right to self-determination and ability to make his or her own health care decisions when provided with information. The nurses acting like a guide or coach facilitated the empowerment of individuals and their family towards engaging in their own self-advocacy. Self-advocacy has been defined as the ability of people to act and advocate on behalf of themselves and their families (WHO, 2003). Hellwig et al. (2003) also found that nurse case managers experienced advocacy as an attempt to empower clients to become their own advocates. The nurses ebbed and flowed between advocating on behalf of

others, and supporting autonomy, depending on the individuals with whom the nurses were working, and the context of the situation.

### **Upholding social justice.**

The nurses noted that people did not always have equal access to the social determinants of health, which included access to resources such as, adequate housing, transport, income, nutrition, education, and health care. Social inclusion, and a life free of stigma and discrimination towards mental illness, was also not always accessible for individuals, or their family members in the nurses' practices. Upholding social justice involved addressing the inequitable distribution of resources, as well as opposing stigma and discrimination. The nurses primarily endorsed social justice on a micro, or individual or family level. The nurses' focus was on recovery of the person and/or family, regardless of the ways in which, the nurses enacted their advocacy activities.

Further insight is derived from understanding the meaning of advocacy from the perspectives of nurses in the psychiatric nurse case manager role. A beginning framework for organizing future practice, education, policy, and research may be drawn from elucidating the meaning of advocacy from the nurses' perspectives; speaking on behalf of someone, supporting the autonomy, and upholding social justice. The understanding of advocacy in the psychiatric nurse case manager role is deepened further by discussing the thematic findings associated with the nurses' experiences.

### **Lessons from the Findings**

Several lessons were stemmed from the findings of the research, which further shed light on the meaning of advocacy from the nurses' perspectives. This chapter is organized around topics which were derived from the themes of the research. The lessons from the findings

included: sharing humanity; avoiding paternalism; resourcing for the journey, developing relationships with colleagues; developing therapeutic relationships; managing time; meeting basic needs; addressing power, stigma, and discrimination; assisting newcomers; and sharing a common vision. Implications for practice, education, and policy are included within each topic area. The discussion section concludes with the strengths and limitations of the study, as well as future directions for research.

### **Sharing humanity.**

The nurses presented themselves as compassionate, genuine, and caring people. The nurses revealed the ways in which they developed human connections with other people, exhibited through their body language, facial expressions, and spoken words. Advocacy was deemed a professional responsibility by the nurses, yet the nurses' humanity could not be fragmented from their nursing roles and advocacy activities. The nurses had to strike a balance by supporting and advocating for others, while not imposing their own values, beliefs, and biases onto the individuals and families involved in their clinical work. The nurses responded to other individuals based upon common humanity, and needs, which was consistent with Curtin's (1979) definition of human advocacy. Adding to this claim, the nurses advocated based upon the person's goals, and not the nurse's goals.

Advocacy was an aspect of the nurses' personal lives and contributed to who they were as people. Being persistent and assertive were personality characteristics, which influenced the nurses abilities to advocate. These findings were in keeping with previous studies (Josse-Ekland et al., 2014; Kubsch et al., 2004; O'Connor & Kelly, 2005).

The nurses provided multiple everyday examples of actions, which they took as part of their advocacy activities. Advocacy was often about simple acts of kindness and the

reinforcement of a person's worth as a human being, who deserved fulfillment of the day-to-day necessities of life. The importance of small acts was supported by a qualitative study from the perspective of 58 persons living with severe mental illness, who shared their experiences of helping professionals (Topor & Denhov, 2015). Topor and Denhov (2015) concluded that "small, everyday actions" (p. 234) were at the foundation of the ways in which professionals supported the recovery process for persons living with severe mental illness.

The reality was that the nurses were on occasion, the only persons available to help people acquire needed resources. The nurses worked with people who were affected by severe mental illness and poverty. Previous researchers suggested that people living in poverty and with severe mental illness were more likely to be socially isolated (Ljunqvist, Topor, Forssell, Svensson, & Davidson, 2016). Advocacy, conducted by the nurses in this context, demonstrated the nurses' moral beliefs, that one should not feel alone entirely during times of crisis, or when needing to problem-solve. Checking in on people, as well as being consistent and available to advocate on behalf of others, when no one else was accessible to help, illustrated the nurses' desire to do the right thing. The nurses were empathic to the situations of people, who were alone. Ljunberg, Denhov, and Topor (2015) reported that persons living with severe mental illness have felt supported during their recovery processes when they have known that their well-being has been remembered, and on the minds of the professionals.

Clinical insight was derived from understanding the humanity attached to the nurses' advocacy activities. In their study about recovery-oriented professionals, Borg and Kristiansen (2004) found that the professional's human qualities mattered more to persons living with severe mental illness than professional titles, training backgrounds, or treatment methods. In a previous study, the ability of professionals to reveal aspects of their human side was deemed important by

persons living with severe mental illness. Ljunberg et al. (2015) found that a helpful component of relationships with professionals was linked to the notion of shared humanness. Persons living with severe mental illness were provided with a sense that professionals could understand their experiences by knowing that they shared characteristics, or experiences on the basis of being human (Ljunberg et al., 2015). Additionally, a sense of shared humanness had the potential to deemphasize differences in power and status between the professional and person living with severe mental illness (Ljunberg et al., 2015). Wheeler (2014) suggested that in addition to learning the tasks associated with psychotherapeutic practices, a requisite for novice psychotherapists was to engage in supervision. The extent of a nurse's self-knowledge was thought to determine the extent to which he or she could understand another person (Wheeler, 2014). Education, which was focused on the value of engaging in ongoing group and individual supervision, could assist the psychiatric nurse case-manager in fostering genuineness, authenticity, and objectivity (Wheeler, 2014). Education, through supervision can alert the nurse to his or her own blind spots, and the ways that personal issues can impact the therapeutic relationship. Engaging in clinical supervision should continue for growth and ethical practice throughout the nurse's career (Wheeler, 2014). Policy-makers in charge of designing service delivery should recognize that the relationship between the nurse and the individual is more than a professional relationship, but also is a relationship between two people. These findings serve as a reminder that in a fast-paced, changing mental health care system, providing value-based services, which offer compassion, is needed.

### **Avoiding paternalism.**

The nurses, having travelled on similar journeys before with individuals, were able to provide suggestions, or information on directions, which the individual with their family may



choose to take towards the individual's recovery destination. Avoiding paternalism was not always easy for the nurses, and challenges existed. The nurses sought to avoid moving forward on any journey with individuals that could be unsafe for themselves, or others.

The nurses understood that declining a person's request could result in the individual not acquiring what he or she wanted, which also could have the consequence of disrupting the therapeutic relationship. The nurses provided isolated examples of requests from individuals that were deemed unreasonable. The nurses had discovered ways to work around minor rules to help people access what they needed, but the nurses were not prepared to engage in an advocacy related activity that could have serious, negative consequences for the individual making the request or themselves. The nurses understood that occasionally people made requests in the context of being ill, and when they were without hope. Rather than, attempting to fix the problem, and assume responsibility on behalf of the person, the nurses talked about the importance of discussing with people the meaning behind their requests. Advocacy, for the nurses, was not about carelessly enabling people, nor was advocacy about rescuing people, or removing people from their responsibilities.

Advocacy involved supporting empowerment and helping people recover a sense of autonomy over managing their illnesses and lives. Avoiding paternalistic nursing practices, as the nurses travelled alongside people on their journeys towards recovery, also was important for the nurses. A delicate balance existed for the nurses, between knowing when to advocate on behalf of someone, and when to encourage the individual to speak on his or her own behalf. The nurses sought to avoid overtaking decisions about the course of an individual's journey. The nurses demonstrated keen awareness that advocating on behalf of others was not entirely the nurse's role to undertake, and the nurses looked for ways to help people develop their spheres of

support. The nurses did not portray themselves as having a monopoly on advocacy on behalf of others, which was in contrast to some of the criticism towards the nursing profession's advocacy activity in the literature (Hewitt, 2002). The nurses were clear that they rejected engaging in advocacy practices that were intended for their own personal gain. The nurses referred to family members, friends, and other community, or health care providers, as also taking on the advocate role on behalf of people. The nurses also encouraged people to access self-help organizations such as the Schizophrenia or Mood Disorder Societies, which provided additional advocacy services.

Spending time with an individual, getting to know the whole person, and his or her history, allowed opportunity for the nurses to help the individual clarify his or her goals for recovery. Getting to know the whole person, beyond his or her diagnoses, also allowed the nurses to know if the individual was able, or ready to advocate on his or her own behalf. The nurses were able to find ways to clarify the 'thin line' between advocacy and paternalism by truly getting to know people, their life experiences, values, beliefs and wishes consistent with similar conclusions drawn by Zomorodi and Foley (2009).

The nurses were aware of the power that their professional statuses exuded. The nurses were holders of specialized knowledge, skills in mental health, and ability in system navigation that naturally placed them in positions of power. The nurses in this study were in positions to exert their influence on others to provide resources for people. The nurses worked together with individuals as allies, in making sure the individuals received care, and support from other professionals or organizations. The power that a professional holds within an organization and the resources that come along with this position were described as aspects that could be helpful to individuals living with severe mental illness (Ljunberg et al. 2015). The nurses described a

dynamic process wherein, the balance of power between the nurse and individual, shifted with time, and according to circumstances. At the beginning of relationships, individuals often were not experienced and lacked information, meaning that they relied on the nurses' expertise. The nurses' advocacy activities changed as people gained more experience, and had more information. The nurses described a shift towards people acting independently and advocating on their own behalves as time moved on, and persons recovered. Laugherne, Priebe, McCabe, Garland, and Clifford (2011) concluded in their study, that persons living with psychotic illnesses wanted a balance in power, between themselves and clinicians, which moved with time, and was dynamic according to the circumstances.

The nurses supported the "dignity of risk" (p.27), or the person's "right to failure" (p.27) as part of a person's personal growth (MHCC, 2015). The nurses did not ignore any risk taking behavior that could impede a person's health, but rather looked for ways to try and teach about any potential hazardous behavior. The nurses worked to try and create partnerships based on a principle of shared-decision making with individuals and their family members. However, the nurses acknowledged, that during times of crisis and episodic periods of illness, a person could lose his or her ability to make informed-decisions. The nurses intervened and advocated for hospitalization when, based on the person's mental status, they believed that a person's safety, or the safety of others, was imminently compromised. The nurses were required to understand and fully appreciate that the ways in which Mental Health Act legislation was used, could place restrictions on a person's autonomy, or right to choose his or her course of action, at moments in time. The nurses stressed that individual choice, and a person's right to self-determination was respected as much as possible, regardless of the way in which the Mental Health Act applied to a

person. Borg and Kristiansen (2004) found that persons living with severe mental illness valued professionals who allowed them to be “*ill* and *well* at the same time” (p. 496).

Implications for practice, education, and policy exist, as a result of the findings discussed in this section. Discussing the meaning behind a person’s request, demonstrating interest in a person’s life, and getting to know the whole person are the recommended ways of avoiding paternalism in practice. Supporting the dignity of taking risks, and providing people with information also helps nurses avoid paternalism. Furthermore, it is important for nurses to recognize and have an understanding of the ways that power shifts between the nurse and those using their services. Psychiatric nurse case managers also have a responsibility to ensure that they are aware of the legal and ethical frameworks that they work within when taking on the advocate role. Jurisprudence is about having an awareness of legislation, regulations, standards, and policies that affect nursing practice (College of Registered Nurses, n.d.). Advocacy can involve some risk as evidenced by some of the examples cited by the nurses, therefore an awareness of jurisprudence is deemed essential, for both protection of nurses and others. The nurses, by way of their professional status, and position within the mental health system were in a position to exude power over individuals, particularly during times of crisis, or illness exacerbation. Understanding the Mental Health Act, and the ways in which the Act impacts their work, is essential for the psychiatric nurse case manager to ensure that restrictions are minimized. Education directed at teaching nurses the importance of informing people of their rights’ under the Mental Health Act, engaging in shared-decision making practices, and understanding informed-consent are recommended to enhance nurses’ advocacy related skills and promote an individual’s autonomy.

Furthermore, practice and education focused on providing an understanding of the relationship between empowerment, autonomy, self-determination, and recovery in relation to advocacy can assist with avoiding paternalistic nursing practices. Missing from the nurses' narratives were the use of tools like recovery action plans, and Advanced Care Directives and education directed at increasing nurses' understanding of the role of these tools may be useful practices. Policy-makers involved in making decisions with regards to service delivery should commit to reducing restrictions on freedoms and involuntary interventions. Creating policies and guidelines that support the expansion and use of recovery action plans, peer support, and use of Advanced Care Directives may assist psychiatric nurse case managers in promoting a person's decision making and autonomy (MHCC, 2015).

### **Resourcing for the journey.**

The nurses identified the factors that helped empower and provide them with the resources to advocate effectively, as they moved forward, alongside individuals and families on their journeys towards recovery. Spence Laschinger et al. (2010) argued that empowered nurses were more likely to empower their patients, resulting in better patient and system outcomes. Experience, learning about systems, and role-modeling were themes, cited by the nurses as having influenced their abilities, to speak on behalf of another, and support a person's autonomy. Each of these themes were consistent with findings from previous studies about the ways in which nurses prepared and learned about advocacy (Choi et al., 2013; Foley et al., 2002; Rainer, 2015). The nurses described supporting the autonomy of individuals and families, in the same ways that the nurses had empowered, or resourced themselves to act in the advocate role. Laugherne et al. (2011) found that individuals living with severe mental illness emphasized that their ability to make choices in their care increased as they became more experienced with their

illnesses. Individuals living with severe mental illness also expressed the need for knowledge, and information in order to feel empowered (Laugharne et al., 2011).

The nurses described the process of learning about advocacy as ongoing and fluid. Advocacy was a component of other nursing roles that the nurses held in the past, yet they had to learn the ways in which advocacy applied in the context of their current role. The individuals, practices, and structures of the various systems that the nurses worked within, also changed over time, adding complexity to the level of knowledge the nurses required to enact the advocate role. The need for ongoing advocacy education was consistent with the findings from Llewellyn and Northway (2007) who found that nurses recommended advocacy education both before and after nursing registration. The nurses' ongoing need for knowledge also is in keeping with Kohnke's (1982) position that advocacy can be facilitated when necessary information has been provided.

Additional insight was derived for practice, education, and policy from understanding the resources that nurses used to empower themselves to advocate on behalf of others, support autonomy, and uphold social justice. Practicing nurses and educators will be interested in knowing that advocacy related skills were developed through experience over time and role-modeling which the nurses observed. Newer psychiatric nurse case managers needed opportunity to observe advocacy in action by spending time with more experienced psychiatric nurse case managers. Additionally, advocacy related education should occur over the course of a nurse's career in order to assist nurses, and hence those they work with, in navigating the complicated systems that they encounter. Nurses required ongoing, up-to-date information about community services and resources for housing, education, transportation, employment and income supports (MHCC, 2015). Ongoing orientation to the various forms, important websites, email addresses and phone numbers of the nurses' institutions, social services, and community

resources, were important aspects of continuing education for nurses in these roles. The nurses brought forward knowledge on the types of information, which they have found helpful to give to people using their services. Sharing information related to the mental health care system, mental illnesses, physical illnesses, self-help organizations, rights of individuals, treatment options, and the ways in which to manage crisis situations was important. Information about the community and places to find volunteer opportunities, leisure activities, and other community resources based on a person's goals also were deemed important to share with people. Policy makers should create policies and structures that support the conditions that allow nurses to engage in experiential learning, and time to gather required information. Furthermore, policy makers should make reporting structure matrixes easily accessible and available, in order to assist nurses with information about who to call upon for assistance and where to bring forward concerns.

#### **Developing relationships with colleagues.**

The nurses valued the opportunity to consult with immediate colleagues, including other psychiatric nurse case managers, occupational therapists, and social workers. The nurses' relationships with psychiatrists had particular influence on their abilities to advocate. The nurses also deemed collaborative partnerships with professionals outside of their ambulatory care departments as essential, and they worked at developing relationships in acute care and the community. The importance that the nurses placed on developing relationships with other health care professionals, was in keeping with several researchers who have reported similar results in their studies (Chafey et al., 1998; Hyland, 2002; MacDonald, 2006; Negarandeh et al., 2006; O'Connor & Kelly, 2005; Young, 2009). The nurses also created relationships with people working outside of health care. Developing relationships with landlords and group home

supervisors was particularly important, in order to help people maintain, or find housing. The nurses also learned that getting to know receptionists, professionals working in other human service agencies, and those individuals at community resources, also could be helpful for assisting people to get what they needed. Partnerships and community collaboration has been considered a “core business” (p. 51) for mental health recovery (MHCC, 2015).

The nurses were required to work autonomously in their positions and one of the benefits to nurturing relationships with colleagues and individuals in other services, or the community, was that during times of crisis someone was available to help. Coming together as a team, with the individual and family at the centre, often created the conditions that supported a person’s recovery and move towards self-advocacy.

The nurses also required the support of their employers as a means of facilitating their advocacy activities, which was consistent with findings from previous studies (Ezeonwu, 2015; Negarandeh et al., 2006). The nurses did not always feel that their advocacy activities were understood by those people in administrative roles. Feeling unsupported by those in leadership roles was problematic because employers can assist nurses with addressing some of the nurses advocacy needs through various bureaucratic channels.

Establishing partnerships with individuals working in organizations both within and outside the mental health sector is consistent with recovery-oriented services (MHCC, 2015) and is important for those in practice, education, and policy. Collaborative and communication techniques were used by psychiatric nurse case managers when they engaged in team work. Advocacy education was important to the psychiatric nurse case manager role and recovery-oriented services (MHCC, 2015). The nurses found exploring and spending time with staff from other agencies helpful in learning about their services. Administrative policy should support



nurses in having the time to create collegial relationships both within and outside their ambulatory care departments, in order to support their advocacy efforts.

### **Developing therapeutic relationships.**

The therapeutic relationship was mentioned in several previous studies as a significant factor influencing nursing advocacy (Chafey et al., 1998; Foley et al., 2000; Josse-Ekland et al., 2014; MacDonald, 2006; Mallik, 1997b; Negarandeh et al., 2006; O'Connor & Kelly, 2005; Snowball, 1996; Tahan, 2005; Watt, 1997; Zomorodi & Foley, 2009). The nurses in the present study expounded on the findings from previous advocacy studies and provided more detailed information on the ways in which, the nurses' perceived the therapeutic relationship to empower others towards developing their own advocacy skills and individual autonomy. The therapeutic relationship has been highlighted as central to nursing practice, and in mental health nursing practice, the therapeutic relationship was named the primary intervention that could help bring about growth, awareness, and/or assistance through difficult times (Dziopa & Ahern, 2008). The nurses expanded on the ways in which the therapeutic relationship influenced their advocacy practices. The therapeutic relationship was described by the nurses, as being at the heart of practice, within the psychiatric nurse case manager's role. Forchuk et al. (2002) suggested that the therapeutic relationship was the "active ingredient" (p. 38) in therapeutic change, which was consistent amongst various types of therapy modalities that could be used in practice. The nurses in the present study developed healing connections with people by using various types of psychotherapeutic treatment modalities.

The nurses were skilled at psychotherapeutic practices and were aware that a key component of engaging in psychotherapeutic practices was the need to know oneself or be self-aware (Dziopa & Ahern, 2008; Grace, 2014). Engaging in processes of self-reflection and

addressing issues of countertransference helped the nurses avoid advocacy practices that could be paternalistic or restrict the autonomy of individuals. Self-reflection was necessary for engaging in therapeutic relationships. Consultation with colleagues was a particularly important means, by which the nurses were able to reflect and check their beliefs and biases. Working with a certain degree of autonomy meant that engaging in some advocacy activities could be a lonely process for the nurses. Advocacy could be stressful therefore, time allocated for consultation and support from colleagues, was essential. The nurses explained that individuals and families were not always aware of the steps involved in their advocacy activities, and burdening individuals with some of the stressors that the nurses felt while advocating was not deemed to be appropriate.

The nurses provided several important insights for future practice and education directed at teaching novice nurses about the practices, which were helpful as part of the therapeutic relationship with people living with severe mental illness. In addition, to engaging in clinical supervision, as previously discussed, a commitment to engaging in reflective practices was essential, and had been recognized as helpful for enabling authentic engagement and the development of collaborative relationships (MHCC, 2015). Various therapy techniques from supportive psychotherapy, group therapy, short-term psychotherapy, and cognitive behaviour therapy were methods to help persons move towards enacting self-advocacy skills. Goal setting and behavior activation were particularly important techniques deemed helpful for people living with severe mental illness to begin the process towards achieving recovery goals.

The nurses also gave several specific psychotherapy recommendations. Providing people with the opportunity to talk about the meanings that people attach to their diagnoses was a finding consistent with the definition of existential advocacy suggested by Gadow (1980). Buck

et al. (2013) recommended various psychotherapeutic techniques that practitioners could use to support persons' recovering from mental illness, which was consistent with the ways that nurses reported supporting the empowerment of people using psychotherapy. The healing process also may involve engaging people in their understandings of grief, loss, or change as part of recovery. A significant amount of time may be devoted to helping people stay engaged in programs or groups. Persons living with severe mental illness reported that the relationships that they had with helping professionals was a factor that helped them with continuing in programs or group therapy sessions (Borg & Kristiansen, 2004). Furthermore, nurses found providing feedback to people about their perceptions to be helpful to recovery. Buck et al. (2013) also suggested that practitioners should devote time to providing direct feedback, about the practitioners' perceptions, of the person's experiences.

Hope was intertwined with the nurses' advocacy experiences and was the thread throughout the therapeutic relationship, which helped individuals and families achieve their goals. The nurses offered people hope by helping them identify their strengths and reminding them of the progress that they had made. The nurses attempted to convey a sense of optimism that recovery was possible by reassuring people that the nurses had successfully helped other people achieve their goals. Conveying a sense of hope and optimism were identified as fundamental ways that mental health providers could assist people towards achieving their recovery goals (Buck et al., 2013; Ljungberg et al., 2015; MHCC, 2015).

The nurses' descriptions of advocacy fit with Jezewski's (1993) model of 'culture brokering, which provided further clinical insight and implications for education content related to the therapeutic relationship. The nurses advocated by interpreting the health care environment for the individuals and families involved in their practices. The nurses provided people, new to

mental health follow-up care, with an orientation about what to expect from their services. The nurses also tried to prepare people for common hurdles to overcome along the road towards recovery. The nurses also described their advocacy activities as bridging, linking, and mediating between different groups, which was consistent with the model of 'cultural brokering' (Jezewski, 1993).

Policies that support therapeutic practices, supervision, and education related to collaborative relationships are a necessary component of recovery-oriented service delivery (MHCC, 2015) and are needed for assisting psychiatric nurse case managers in their abilities to support the autonomy of others.

### **Managing time.**

The nurses were busy professionals. Time was a valuable resource and the nurses were constantly budgeting and managing the ways that the hours of their days were spent. Advocacy did not always occur in one moment for the nurses, but also over the course of time. Vaartio et al. (2006) also suggested that advocacy was not always a single event. Advocacy for the nurses was time consuming and the volume of paperwork added to the pressures that the nurses faced. Advocacy also involved deadlines and the right timing. The nurses stressed the importance of having the autonomy to be flexible with their time, particularly during times of crisis. The nurses met with people in between regular visits, either face-to-face, or by phone. Topor and Denhov (2012) found that persons living with severe mental illness access to professionals in between visits to be helpful.

The nurses described working within a pressured mental health system, where they were expected to facilitate a steady flow of people through their ambulatory care departments, in order to meet the demand for their services. At the same time, the nurses were acutely aware of their

need to provide quality mental health services that centred on individual need. The nurses' time was filled with balancing and responding to the day-to-day demands of both these expectations. Tahan (2005) found that advocacy helped case managers balance the needs of a hospital or employer with the needs of individuals and families.

The nurses explained that the recovery process, which involved time and readiness to engage in treatment, also varied amongst individuals. The nurses spoke of trying to meet the needs of two populations of individuals using their services over the course of time. One group of individuals, who experienced the effects of mental illness and poverty more deeply, required ongoing formal support spanning over years. The other group of individuals, who were newer to the nurses, were discharged when a certain degree of functioning was met but not necessarily when long-term goals for recovery had been achieved. During the initial stages of a therapeutic relationship, preparing people for the time-limited nature of the relationship was deemed essential. Preparing people for the termination of therapeutic relationship was thought to help ease the transition towards independence, post-discharge from ambulatory care services. The nurses tried to avoid having individuals become too dependent on them, in order to circumvent practising in a paternalistic, care-taking manner. The nurses encouraged people to increase their spheres of support, as a means of promoting autonomy outside of the relationship with the nurse, but also to prepare people for termination of the therapeutic alliance. At the same time, the nurses exhibited their understanding that some individuals valued the long-term relationships, and the nurses shared the challenges of discharging people in these circumstances. According to the nurses, being there and available to assist individuals access their basic needs and problem-solving during times of crisis was helpful for those living with severe mental illness.. Borg and Kristiansen (2004) found that the presence of a single particular helper, who was an essential

thread of continuity and safety during difficult times, was valued by persons living with severe mental illness.

Topor and Denhov (2012) suggested that considering the quantity of time and the quality of time were important aspects of understanding the development of working alliances between professionals and persons living with severe mental illness, which has implications for practice, education, and policy-making. Sensitivity is needed when considering the impacts of discontinuing relationships and the amount of time a nurse spends with a person. Ljunberg, Denhov, and Topor (2016) found that discontinuity in relationships and insufficient time spent with professionals was problematic for individuals living with severe mental illness. Practicing nurses and educators in charge of teaching about therapeutic practices need to be aware of the importance of preparing people for discharge at the onset of the therapeutic relationship (Wheeler, 2014). Education focused on time-management skills can assist nurses within the psychiatric nurse case manager role in finding ways to budget their time, so that nurses can prioritize their practice in a way, that is flexible and responds to the needs of people using their services. Organizations that are too routinized and rule-governed need to ensure that policies are in place to support professionals in their roles (Ljunberg et al., 2016). Professionals and service-users require some autonomy in the ways that their relational work is conducted over time (Topor & Denhov, 2012) and should be recognized by those creating policies and program development. Finding ways to reduce the need for onerous paperwork also should be considered by those creating guidelines and policies. The results of this study support the claim that the management of time is an important factor in the creation of a working alliance and should be given greater attention in the development of experience and evidence-based practices (Topor & Denhov, 2012).

**Meeting basic needs.**

The nurses directed their advocacy activities towards helping people access their basic needs, which is one of the ways that the nurses supported social justice. The framework based on the work of Maslow (1970) was centred on a hierarchy of needs, beginning with basic physiological survival needs, to higher-level needs, such as those for belonging and esteem, and ending with self-transcendent needs. The nurses prioritized their advocacy activities largely in keeping with this framework. Perese (2007) suggested that individual nurses could advocate for social justice by helping people access safe housing, transportation, personal safety, nourishing food, appropriate clothing, and social activities, which was consistent with the ways that nurses in this study advocated for social justice related issues. The nurses found if they did not attend to a person's basic needs, negative outcomes could arise leading to increased stress, an exacerbation of symptoms, and possibly rehospitalisation, which supports claims made by Stylianos and Kehyayan(2012).

In the initial stages of a therapeutic relationship, the relationship between the nurse and the individual was often less focused on therapy and more focused on practical assistance. De Leeuw, Van Meijel, Grypdonck, and Kroon (2012) spoke about the benefit of providing practical assistance and everyday problem solving during the initial stages of a working alliance. Focusing on practical matters in the initial stages of a working alliance was thought to help create trust and encourage individuals to undergo further treatment (De Leeuw et al., 2012). The nurses noted that occasionally, people would become stuck along their journeys towards recovery and the challenge was often related to overcoming socioeconomic related issues. The nurses highlighted the importance of initiating discussions with people around their social and economic situations, throughout the course of a therapeutic relationship, in order to help people

move along their recovery trajectories. Listening and learning about a person's socioeconomic status was thought to help recovery-oriented practitioners to identify the ways to address the factors that may impact health (MHCC, 2015). The nurses also found that a person's self-esteem or beliefs about his or herself could preclude the person's ability to meet basic needs, which is consistent with one of the consequences of self-stigma cited in previous literature. Self-stigma refers to the "internalization of negative social stereotypes, which in turn has an impact on people's sense of identity and leads to reduced self-esteem and diminished expectations" (MHCC, 2015, p. 40). Understanding self-stigma is important because when people underestimate their abilities or anticipate rejection, they are less likely to pursue opportunities or advocate for their rightful entitlements (MHCC, 2015).

Livingston (2013) suggested that mental health service providers and their professional bodies could serve as strong advocates for the equitable distribution of resources to the mental health care system and for the treatment of people living with mental illness. Perese (2007) suggested that psychiatric nurses should include inquiries around issues of poverty in nursing assessments and treatment planning, which is in keeping with the recommendations from the nurses in this study. Addressing issues of self-stigma is one of the ways in which people can be supported towards accessing their basic needs. These finding should be of interest for nurses, as well educators when teaching psychotherapeutic practices. The findings of this study support the development recovery-oriented practice and service delivery, which includes ways to address inequitable living circumstances and unequal opportunity (MHCC, 2015) . Additionally, the psychiatric nurse case manager has knowledge to create necessary policy changes that address issues of inequity at institutional, local, and societal levels (Grace, 2014).

### **Addressing power, stigma, and discrimination.**



Stigma and discrimination against individuals living with mental illness has been well documented (Bates & Stickley, 2012; Livingston, 2013; MHCC, 2012, 2013; WHO, 2003). The nurses supported social justice by tackling stigma and discrimination on an individual basis. The nurses shared multiple examples of stigma, discrimination, and social injustice from their work, which builds on the current body of evidence that exists on these topics. The number of examples, that the nurses shared, supports the claim that few areas of social policy affecting people living with mental illness remain untainted by stigma (Livingston, 2013). Diagnostic overshadowing, disrespectful and stigmatizing attitudes, and failure to understand the needs of the people using their services, were some of the ways in which the nurses witnessed stigma and discrimination, exhibited by health and human service providers. The nurses also shared the ways in which staff members of government agencies, other human services, and private sector institutions, through their structures and policies, disempowered people living with mental illness. Nurses' advocacy activities could be directed at supporting people affected by stigma in the workplace and in leisure activities. Safe, adequate housing and affordable medication options for lower income families were not always easily accessible for the people involved in the nurses' practices and required advocacy.

The nurses revealed individual ways of tackling stigma such as speaking up when disparaging remarks were made about persons with lived experience of mental illness. Supporting workplace inclusion for individuals with lived experience was a form of protest, consistent with one of six anti-stigma approaches identified to address issues of stigma and discrimination towards mental illness (Arboleda-Flórez & Stuart, 2012).

The plethora of examples, which the nurses provided related to their experiences associated with the stigma and discrimination towards individuals living with mental illness,

added credence to the claim that nurses must find ways to “walk the talk” of stigma reduction (Gouthro, 2009, p. 674) as part of their practice. One of the six nurses in this study used the term stigma when discussing her advocacy experiences. Otherwise, the nurses did not use terms such as stigma, discrimination, or social injustice when discussing these issues, although they describes such events.. Leaders in psychiatric clinical work can act as role models by labelling stigmatising behaviours and language when observed as a form of anti-stigma protest (Abbey et al, 2011). Blodorn, O’Brien, and Kordys (2012) suggested that people were less likely to perceive institutional forms of discrimination, as compared to individual forms of discrimination. Grace (2014) explained that nurses were in positions to recognize existing and developing patterns of injustice and disparity. The nurses involved in this study were in positions to recognize existing and developing patterns of injustices within institutional forms of discrimination. In order to bring about systemic and policy change, the collective voice of the nurses needs to be heard. The nurses were familiar with recovery-oriented practices and demonstrated the ways in which they practised following this philosophy of care in multiple ways. More in depth knowledge, on recovery-oriented practices particularly focusing on the ways in which the nurses can address stigma, discrimination, and inequities, as well as ways to support the social determinants of health, on a more macro-level are needed. Education including curricula about stigma and discrimination in initial training and in continuing education should be provided to nurses throughout their careers (Ross & Goldner, 2009). Livingston (2013) provided the same direction and argued that those responsible for continuing education programs and accreditation organizations should ensure recovery-oriented care principles were embedded within the policies of mental health organizations and mental health services in order to tackle stigma and discrimination.

These findings, further support the claim that addressing issues of stigma and discrimination should take place across different sectors of society (Manitoba Department of Healthy Living, Seniors and Consumer Affairs [MDHLSCA], 2011; MHCC, 2015). Reducing stigma and discrimination requires a shared approach at a systems, community, program, and individual level (MHCC, 2015) and policy supporting this collective approach also should be created.

### **Assisting newcomers.**

The nurses described working with people, who were new to Canada through immigration and refugee status. The nurses demonstrated compassion for the ways in which institutional practices could impact individuals, who had no experiences with Canadian laws and health care organizations. English, spoken as a second language could add to a person's struggles, particularly during times of crisis. The nurses explained that the ways in which, practices associated with the Mental Health Act were enacted, could compound the traumas of immigrant or refugee families. The nurses cited examples of many ways that stigma and discriminatory actions permeated the institutions and practices that were designed to help people living with mental illness. The foreignness of managing a mental illness in a new country compounded an individual's struggles, according to the nurses. Discrimination and barriers to access may increase health disparities and impede people with immigrant and refugee backgrounds from exercising their rights and getting the help that they need (MHCC, 2015).

The findings from this study support the need for people to have information available to them in easy-to-read language and via interpretation on common mental health related topics (MHCC, 2015), particularly on helpful ways to manage crisis situations. Educators and policy-makers should refer to the document, *Guidelines for Recovery-Oriented Practice* (MHCC, 2015),

which contains information on ways to address the educational and policy related needs of immigrants and refugees, as well as members of ethnocultural and radicalized communities. The MHCC (2015) referred to the skills and behaviors that were needed by mental health practitioners working with immigrant and refugee populations, in addition to the ways that process and service initiatives could be enhanced through policy.

### **Sharing a common vision.**

The nurses focused their advocacy activities towards a micro or individual/family level. This finding was consistent with the conclusions drawn by previous researchers, who determined that advocacy efforts directed at a macro societal level were often missing from the practice of nurses engaged in clinical settings (Hanks, 2013; Spenceley et al., 2006). In addition to focusing their advocacy efforts at an individual level, the nurses shared a common vision with others, as part of a collective journey. The nurses believed in a recovery-oriented philosophy of care, consistent with the beliefs of the wider mental health community. The nurses' advocacy experiences were intertwined with their experiences of recovery for individuals and families. The MHCC (2015) suggested that recovery was a journey not only for a people living with mental illness and their families, but also for everyone involved in providing support and services. The nurses directed their advocacy efforts towards issues related to poverty and injustices such as stigma and discrimination, which have roots arising from divisions in society (Elliot & Masters, 2009; Livingston, 2013). Tackling issues related to poverty and injustices mattered to all of the nurses in this study, and were concerns they collectively shared. Supporting social inclusion and advocacy on the social determinants of health were recognized components of recovery-oriented practice and service delivery (MHCC, 2015).

Spenceley et al. (2006) suggested that advocacy focused solely on the individual level, has resulted in limited assessment of the root causes of injustices and inequities, which has lead nursing to pursue short term, one-off solutions to the individually experienced effects of systemic issues. The nurses described their lack of control over making changes at a systemic or societal level, which was problematic given that many of the issues the nurses identified had roots derived from society. The nurses developed ways of working around systems or institutions that created policies or practices that impeded an individual's ability to achieve his or her goals. The nurses were savvy and advocated effectively through negotiation with community partners. The nurses were keenly aware of the ways that their reputations and the reputations of individuals in their care, could impact resources allocated to other people in the nurses' care in the future. The nurses had to strike a balance between advocating for one person while at the same time not disadvantaging other people, which was consistent with claims made by Grace (2014). The nurses also, occasionally practiced "responsive subversion" (Hutchinson, 1990, p. 3), or rule-bending for the sake of the individuals in their care, when negative consequences for individual well-being existed because certain rules seemed too rigid. The nurses objected to some of the ways that transportation allowances were allocated for people accessing their services, which resulted in the nurses occasionally, bending the rules to suit the best interest of the individual. Being savvy, negotiating, and rule-bending were effective strategies that allowed the nurses to work around larger systemic or societal issues to get people what they needed. However, these strategies did not target some of the root causes of the inequities that impacted the individuals in the nurses' practices

Understanding the psychiatric nurse case managers' absence from advocacy towards injustices, stigma and discrimination at a macro-level is beyond the scope of this study.

However, the nurses' collective journey towards addressing stigma, discrimination, and injustices on a more macro-level has begun, by documenting their experiences through research. Structural stigma has been referred to as the "rules, policies, and practices of social institutions that arbitrarily restrict the rights of, and opportunities for, people with mental illness" (Livingston, 2013). Livingston (2013) suggested that little research on structural stigma has occurred in Canada, and often structural stigma has been difficult to detect and document. Livingston (2013) further proposed that stigma could not be eliminated without attending to structural stigma because issues of inequities and injustices have been often woven into the practices and policies of institutional settings. The nurses spoke of working with individuals deeply impacted by some of the practices associated with institutions like health and government agencies. Clarity is needed to further understand, whether some of the examples cited by the nurses were isolated incidents, or recurrent patterns of problematic organizational culture associated with structural stigma. Livingston (2013) suggested that documenting empirical evidence of structural stigma has the advantage of allowing future mental health and human rights advocates know where to prioritize, or direct advocacy efforts to bring about change.

The nurses in this study, reflected on the ways that they became empowered to practice advocacy on a micro-level. Perhaps those same methods, including experience, learning about systems, and role-modeling can be used to empower nurses to affect policy change on a more macro-level in order to help address the root causes of structural forms of injustice, stigma, and discrimination. Nurses could become empowered to bring about policy change at an institutional or societal level through more experience and exposure at affecting change on a macro-level, such as engaging in research or working with community advocacy groups. Additionally,

education on advocacy related topics and social justice issues could increase nurses' collective presence at a macro-level.

### **Strengths and Limitations**

This inquiry enabled the illumination of deeper meanings that nurses associated with advocacy in the psychiatric nurse case manager role, within the context of ambulatory care settings. Clinical insight and further understanding related to advocacy practices were derived from the findings of this study. The meaning of advocacy from the nurses' perspectives including speaking on behalf of someone, supporting autonomy, and upholding social justice, could provide a beginning framework for organizing future education and research on nursing advocacy. The data, which were collected, were rich, which allowed for meaningful analysis to occur, and was a strength of the research. This study involved some limitations. The findings of the study cannot be generalized to the broader nursing context, given the focus on the psychiatric nurse case manager role and ambulatory care setting, as well as the limited number of participants. The nurse participants in this study were all female. Perhaps the voice of male psychiatric nurse case managers would have expanded the findings of the research. Similarly, a study including nurses with less experience may have yielded differing results.

### **Future Research Directions**

The findings of the study may be used as a beginning foundation for understanding advocacy within the mental health nursing context. Additional studies within the context of community mental health and acute care mental nursing roles may be useful. The perspectives on nursing advocacy of persons and families with the lived experience of mental illness were missing from the research literature. The perspectives of persons with lived experience could enhance the advocacy practices of mental health nurses, as well as inform, the ways to create

partnerships to address larger societal issues such as poverty, stigma, and discrimination.

Research related to ways that nurses have experienced structural stigma (Livingston, 2013) or undertaken advocacy at the societal level may contribute to understanding and addressing discrimination and stigma related to mental illness at a macro-level.



## **Chapter Six - Conclusion**

Advocacy long has been associated with the nursing profession, yet seldom has been addressed in nursing research. The journey towards understanding advocacy has begun, within the context of the mental health nursing specialty. Van Manen's (1997) hermeneutic phenomenological method was used to bring to light a deeper appreciation for the critical role of psychiatric nurse case managers, as they practice advocacy. Furthermore, the results of this study lend support to the claim that advocacy is a component of a recovery-oriented mental health system.

The use of a metaphorical journey helped to describe the nurses' lived experiences. Six themes emerged from the nurse interviews including embarking on a journey, resources for the journey, travelling solo and with others, the journeys and time, types of journeys, and collective journeys. The nurses' perspective on the meaning of advocacy within the psychiatric nurse case manager role was derived from these themes. The themes also offered lessons for practice, education, and policy.

The meaning of advocacy was found to be a dynamic process that involved speaking on behalf of others, supporting autonomy, and upholding social justice. The nurses spoke on behalf of others when they had established that a person was not able to use his or her voice to express wants, needs, or concerns. Supporting autonomy involved the nurses' respect for a person's right to self-determination and abilities to make his or her health decisions when provided with information. The nurses facilitated a person's empowerment by acting as a coach, as the person moved towards engaging in his or her self-advocacy. The nurses enabled social justice by addressing the inequitable distribution of resources, as well as opposing stigma and discrimination. The nurse's actions ebbed and flowed between speaking on behalf of another

and supporting a person's autonomy depending on the person and context of a situation. The development of theory may be derived from reflection (van Manen, 1997). Theory then is used to enlighten practice (van Manen, 1997). The meaning of advocacy from the nurses' perspectives was enriched by reviewing several lessons stemming from the findings of the study.

Advocacy was considered part of the nurse's role, and also was about connecting with others in thoughtful, compassionate ways, which included engaging in small acts of everyday kindness, as part of sharing humanity. Avoiding paternalistic nursing practices, sharing power, and decision making with individuals and families, also was important for the nurses. Resourcing for the journey referred to the ways in which the nurses learned to advocate and involved experience, learning about systems, and role-modeling. Learning about advocacy was fluid and occurred throughout a nurses' career. The nurses continually needed updated information in order to navigate the multiple systems within which they worked. Exposure to other nurses' advocacy activities was helpful for nurses to learn ways to take on the advocate role. In turn, the nurses noted that through experience, learning about systems, and role-modeling, individuals and families were empowered in their roles as self-advocates.

The nurses were continually developing relationships with others while working in a role that also required the nurse to be able to work independently. Relationships with colleagues were essential for effectively advocating. Collaboration and consultation with immediate colleagues, professionals from acute care settings, community workers, and staff from other health services were valued by the nurses. Partnerships with people from human service sectors, landlords, and community agencies also were important. Advocacy was fostered by positive relationships with management. Developing the therapeutic relationship was crucial for the nurses as a means of assisting people towards their recoveries. The nurses used different types

of therapy modalities, which included supportive therapy, cognitive-behaviour therapy, short-term psychotherapy, and group therapy as means of helping people to heal. Hope was an essential ingredient to the therapeutic relationship, and the nurses used hope to help people envision a future where recovery was possible. Engaging in self-reflective practices was imperative for the therapeutic relationship, which allowed the nurses to check their biases, values, and beliefs.

Managing time effectively was necessary for the nurses given the busy environments within which they worked. Advocacy could be time consuming and the demand for the nurses' services meant that the nurses had to continually manage deadlines, be flexible, and set priorities for use of their time. The nurses had to balance the needs of those people, who were involved with the nurses' practices over the long-term, with the needs of people newer to the nurses' practice. Preparing people for the ending of the therapeutic relationship was a necessary step in helping people to move forward.

The nurses prioritized their advocacy efforts towards helping people access their basic needs. The nurses made inquiries about a person's socioeconomic situation throughout the therapeutic relationship, to ensure a person was meeting his or her day-to-day needs. Self-stigma also could be a barrier that prevented a person from accessing the social determinants of health. Issues of power, stigma, and discrimination permeated the nurses' examples of the ways in which they directed their advocacy activities. The findings of this study indicate that a need exists for nurses to be able to detect and name structural forms of stigma given their intimate knowledge at navigating the systems where injustice often is present. Newcomers to Canada could face deeper suffering related to the effects of stigma and discrimination, particularly if English was spoken as a second language.

The nurses were united in their common vision towards addressing stigma, discrimination, and social injustices despite being absent from advocacy enacted on a larger, macro-level scale. The nurses often did not feel that they could affect change at an institutional, community, or societal level. The nurses travelled on the roads towards recovery, as defined by the person or family, by mainly focusing their advocacy activities on a micro individual or family level. The nurses developed skills at working around the systemic barriers that precluded their abilities to help people achieve their goals. Being savvy, negotiating, and rule-bending were effective strategies that often worked, however the root causes of many of the injustices that the nurses encountered, were not addressed.

Nurses have a long tradition of advocating and combining their voices to address societal issues. Together, with those, who share a common vision, psychiatric nurse case managers have a role to play, in transforming services and systems, in addition to bringing about equity and inclusion for people living with mental illness. The nurses' collective journey towards addressing the root causes of the issues that matter to them, and the people they work with everyday, has started. The nurses, having lent their voices to this research, allowed for a deeper understanding of advocacy, which has implications for advocacy practice, education, and research. Furthermore, future mental health and human rights advocates also may be interested in the findings of this study, which has the potential to bring about change, and bring fairness and justice to the lives of people living with mental illness.

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**Appendix A: Tri-Council Policy Statement Certificate**



## **Appendix B: Interview Guide**

### **Advocacy: The Experience of Psychiatric Nurse Case Managers**

You have been asked to participate in this study because your professional role entails psychiatric nurse case management in an ambulatory care setting for individuals living with a serious and persistent mental illness. The purpose of this study is to explore your lived experience of engaging in advocacy related activities and behaviours within this role.

With your consent this interview is being audio-recorded. I must report any information that is collected regarding the abuse of clients in care. If at any point in the interview you feel uncomfortable and wish to stop please let me know. You may choose not to answer some questions. Take as much time to think about and answer the questions as you need. Your responses are confidential. My thesis supervisor, a transcriptionist who has signed an oath of confidentiality, and I are the only individuals who will have access to your responses to these questions. When transcribed, any names present will be removed and efforts will be made to remove any identifiable features of your interview.

#### **Professional History**

In order to understand your professional role, I would like to start by asking you some general demographic questions related to educational background and areas of experience as a nurse. Refer to Appendix B, the demographic questionnaire.

#### **Interview Questions:**

1. What does advocacy mean to you?
2. Considering your current role, please describe your experiences advocating for individuals living with a severe and persistent mental illness?
3. Please describe what your experience related to the factors that facilitate advocacy?
4. Please describe a time when you made a decision not to advocate?
5. What advice or tips about advocacy would you give to others in your role as a psychiatric nurse case manager?



**Appendix: C****Advocacy: The Experience of Psychiatric Nurse Case Managers****Letter of Invitation**

(to be placed on Brandon University letterhead)

Dear RN/RPN,

I am a student in the Master of Psychiatric Nursing Program through the Faculty of Health Studies at Brandon University. I am conducting a research study as part of the requirements of my program and I would like to invite you to participate in my study. My thesis advisor is Dr. Fran Racher. The title of my thesis is "Advocacy: The Experience of Psychiatric Nurse Case Managers".

The knowledge gained through this research will increase our understanding of advocacy in nursing. Psychiatric nurse case managers working with individuals living with a severe and persistent mental illness may be assisted to develop skills and more meaningful practices related to advocacy, which is in keeping with a recovery, or client-oriented system of mental health care. Additional theory, practice, policies, and education related to advocacy in nursing may also be derived from the findings of this study. Results of this study will be presented at scholarly conferences and in publications.

If you volunteer to participate in this study, you will be asked to take part in an interview that will last approximately 60-90 minutes. The interview will be conducted at a time and place of your convenience. The interview will be audio-taped and transcribed by a transcriptionist. You will also be asked some demographic questions about, for example, your age, nursing education, and nursing experience.

Your name will not appear in any report or publication of the research. Your data (e.g., interview recording, transcripts of interviews) will be safely stored in a locked cabinet and on a password-protected computer and only my thesis committee, a transcriptionist who has signed an oath of confidentiality and I will have access to the data. Your identity will be protected by use of pseudonyms or false names. When your interview is transcribed, your name will be removed and efforts will be made to remove any features of your interview that could make you identifiable. All data will be destroyed after the completion of the study. Paper copies will be shredded and electronic files will be deleted.

Participation is voluntary and you may refuse to answer any question or withdraw from the study at any time. Participating or declining to participate in this study will not affect your relationship with the researcher or Brandon University.

Thank-you for taking the time to read this information. If you have any questions about the study, you may ask me or my advisor at the contact information given below. This research has been approved by the Brandon University Ethics Committee (BUREC). If you so wish, you may contact them for questions regarding ethics at (204)727-9712 and [burec@brandonu.ca](mailto:burec@brandonu.ca). If you would like to participate in this study please contact me either at the phone number or email listed below.

Kind regards,

Tina Curtis, RPN, BScPN  
Master of Psychiatric Nursing Student  
Faculty of Health Studies  
Brandon University  
Phone: (204)952-3408  
Email: [curtistl99@brandonu.ca](mailto:curtistl99@brandonu.ca)

Dr. Fran Racher  
Master of Psychiatric Nursing  
Faculty of Health Studies  
Brandon University  
Phone: (204)727-7414  
Email: [racher@brandonu.ca](mailto:racher@brandonu.ca)

## Appendix D: BUREC Ethics Certificate




### Brandon University Research Ethics Committee (BUREC) For Research Involving Human Participants

## ETHICS CERTIFICATE

The following ethics proposal has been approved by the BUREC. **The approval is valid for up to five (5) years from the date approved, pending receipt of Annual Progress Reports.** As per *BUREC Policies and Procedures*, section 6.0, "At a minimum, continuing ethics research review shall consist of an Annual Report for multi-year projects and a Final Report at the end of all projects... Failure to fulfill the continuing research ethics review requirements is considered an act of non-compliance and may result in the suspension of active ethics certification; refusal to review and approval any new research ethics submissions, and/or others as outlined in Section 10.0".

Any changes made to the protocol should be reported to the BUREC prior to implementation. See *BUREC Policies and Procedures* for more details.

As per *BUREC Policies and Procedures*, section 10.0, "Brandon University requires that all faculty members, staff, and students adhere to the *BUREC Policies and Procedures*. The University considers non-compliance and the inappropriate treatment of human participants to be a serious offence, subject to penalties, including, but not limited to, formal written documentation, including permanently in one's personnel file, suspension of ethics certification, withdrawal of privileges to conduct research involving humans, and/or disciplinary action."

<b>Name of Principal Investigator:</b>	Ms. Tina Curtis, Brandon University
<b>Title of Project:</b>	Advocacy: The Experience of Psychiatric Nurse Case Managers
<b>Co-investigator(s):</b>	n/a
<b>Faculty Supervisor: (if applicable)</b>	Dr. Fran Racher, Faculty of Health Studies (Psychiatric Nursing) Brandon University
<b>Research Office File #:</b>	21685
<b>Date of Approval:</b>	March 23, 2016
<b>Ethics Expiry Date:</b>	March 23, 2021
<b>Authorizing Signature:</b>	 Dr. Shannon Gadbois Interim Chair Brandon University Research Ethics Committee



**Appendix: E****Advocacy: The Experience of Psychiatric Nurse Case Managers****Consent Form**

(to be placed on Brandon University letterhead)

Dear Participant,

**Research Project Title**

Advocacy: The Experience of Psychiatric Nurse Case Managers

**Principal Investigator**

Tina Curtis, Student, Master of Psychiatric Nursing Program, Faculty of Health Studies, Brandon University. Phone (204)952-3408 or email: curtistl99@brandonu.ca

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**Research Supervisor**

Dr. Fran Racher, Master of Psychiatric Nursing Program, Faculty of Health Studies, Brandon University. Phone (204)727-4714 or email: racher@brandonu.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea the research and your participation. If you would like more detail about something mentioned here, or information not included here, please feel free to ask. Please take the time to read this consent form carefully and to understand any accompanying information.

You are invited to participate in a study entitled "Advocacy: The Experience of Psychiatric Nurse Case Managers" which is being conducted by me.

**Purpose and Objectives**

The purpose of this study is to explore the advocacy experiences of psychiatric nurse case managers who work in an ambulatory care setting with adults living with a severe mental illness. Investigation of advocacy is of particular significance to nursing knowledge since research findings may assist psychiatric nurses in developing skills and more meaningful practices related to advocacy that is in keeping with a recovery, or client-oriented system of mental health care. Additional theory, practice, policies, and education related to advocacy in nursing may also be derived from the findings of this study.

**Inclusion Criteria and Participation**

You are being asked to participate in this study because you are either a registered nurse (RN) or registered psychiatric nurse (RPN) who is employed in ambulatory care as a psychiatric nurse case manager for adults living with severe and persistent mental illness. Participation in this study is voluntary. You may stop at any time without any consequence or any explanation. You may decline to answer any question or you may withdraw from participating in this study by letting me know directly any time during the interview. You may also withdraw from participating following the interview by contacting me by phone at (204)952-3408 or email at [curtistl99@brandonu.ca](mailto:curtistl99@brandonu.ca) up until completion of the study. If you withdraw from the study, your data will not be used and it will be destroyed.

### **What is involved?**

If you agree to participate in this research, you will be asked to take part in an interview that will take approximately 60-90 minutes. The interview will be conducted at a mutually agreed upon time and private place. You will also be asked to complete some demographic questions, including age, education, and experience.

### **Risks**

Participation in this study may cause some inconvenience to you, including the time it takes to be interviewed. If at any point in the interview you feel uncomfortable and wish to stop please let me know. As a participant you have the opportunity to withdraw from the study at any time. If you do not wish to discuss a particular question please let me know and the question will be omitted. It is not anticipated that any information will be collected regarding the abuse of clients in care, however the researcher has a duty to report if this is disclosed.

### **Benefits**

The knowledge gained through this research will increase our understanding of advocacy in nursing and is an opportunity to share experiences of this phenomenon. Present and future psychiatric nurse case managers working with individuals living with a severe and persistent mental illness may be assisted to develop skills and more meaningful practices related to advocacy which is in keeping with a recovery, or client-oriented system of mental health care. Additional theory, practice, policies, and education related to advocacy in nursing may also be derived from the findings of this study.

### **Confidentiality**

Your interview will be audio-recorded and transcribed by a transcriptionist. The transcriptionist will sign a confidentiality agreement prior to receiving any data collected from your interview. Audio recording the conversation will allow me to transfer our dialogue into notes. I may also take a small amount of handwritten notes during our interview. The computer files and transcripts of our conversations will be kept confidential and only accessed by myself, Tina Curtis, Dr. Fran Racher, and the transcriptionist. The computer files will be saved on a flashdrive

and safely stored with the notes in a locked filing cabinet and password protected computer. Your identity will be protected by use of pseudonyms or false names. When your interview is transcribed, your name will be removed and will not appear in any report, publication, or presentation of the research. I may quote you to illustrate a point however efforts will be made to remove any features of your interview that could make you identifiable.

### **Dissemination of Results**

It is anticipated that the results of this study will be shared with others in the following ways: published articles, posters or presentations at conferences, and as a thesis presentation. Research findings will be shared with study participants following completion of the study via an email link to the thesis.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation at any time. If you have any questions please do not hesitate to contact myself or my supervisor directly at the phone number or emails provided.

This research has been approved by the Brandon University Research Ethics Committee (BUREC). If you have any questions regarding ethics, they may be contacted at (204)727-9712 and [burec@brandonu.ca](mailto:burec@brandonu.ca). A copy of this consent form will be given to you to keep for your records and reference.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Researcher's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Appendix F: Demographic Data Collection Tool**

1) Participant #:

2) Pseudonym:

3) Age

4) Gender

5) ☐ Registered Psychiatric Nurse ☐ Registered Nurse

6) Nursing Education:

☐ Diploma

Year Completed\_\_\_\_\_

☐ Baccalaureate

Year Completed\_\_\_\_\_

☐ Graduate Degree (Explain below)

Year Completed\_\_\_\_\_

\_\_\_\_\_

☐ Other (Explain) \_\_\_\_\_

7) Total years of nursing practice:\_\_\_\_\_

8) Total years of non-psychiatric nursing practice: \_\_\_\_\_

If so, in what type of setting? (e.g. acute, community/ emergency, ICU)\_\_\_\_\_

9) Total years of psychiatric nursing practice: \_\_\_\_\_

10) Areas worked in mental health: \_\_\_\_\_

Length of time working in current area of psychiatric nursing case  
management:\_\_\_\_\_

**Appendix G: Field Notes**

Code #/Pseudonym \_\_\_\_\_

Date \_\_\_\_\_

1. Thoughts regarding how the interview went (e.g., flow, any interruptions or distractions, etc.).
  
2. Were there any issues with any of the questions on the interview guide? Please describe.
  
3. Based on this interview, any thoughts on additional questions that could be added to the guide?
  
4. Anything that particularly stood out in this interview (e.g., any interesting insights, concerns, etc.)
  
5. What emotional reactions did I experience during this interview?



**Appendix H: Transcriptionist Confidentiality Agreement**

(to be placed on Brandon University letterhead)

I, \_\_\_\_\_ transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentations received from Tina Curtis related to her research study on the researcher study titled (name of research study). Furthermore, I agree:

1. To keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., tapes, transcripts) with anyone other than Tina Curtis, the researcher on this study and to hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews.
2. To not make copies of any audiotapes or computerized titles of the transcribed interviews texts, unless specifically requested to do so by the researcher, Tina Curtis.
3. To store all study-related audiotapes and printed transcript materials in a safe, secure location as long as they are in my possession.
4. To keep all transcript documents and digitized interviews in computer password-protected files and close any transcription programs when temporarily away from the computer.
5. After consulting with the researcher, Tina Curtis, delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

\_\_\_\_\_  
Signature of transcriber

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of principal researcher

\_\_\_\_\_  
Date